RECEIPT

Circuit Court Clerk, Debbie Moss Wilson County Circuit Civil Court

134 S. College St. Lebanon, TN 37087 (615)444-2042

No: Receipt Date: System Date:

216929 01/05/2016 01/04/2016

Total Amount Paid: \$84.00 Received Of: Sarah Katherine Rodgers

Payment Method/No: Cash

\$85.00

Amount Tendered: Amount Returned: \$85.00 \$1.00

Case: 95CC1-2015-CV-592

PAID IN FULL

Linda Caldwell vs SSC Lebanon Operating Company LLC (et. al);

Amount Paid:

84.00

Page 1 of 1

Debbie Moss

Mary Hamblen,

RECEIPT

Circuit Court Clerk, Debbie Moss Wilson County Circuit Civil Court

134 S. College St.

Lebanon, TN 37087

(615)444-2042

No:

216929

Receipt Date: System Date: 01/05/2016 01/04/2016

Total Amount Paid: \$84.00 Received Of: Sarah Katherine Rodgers \$85.00 Payment Method/No: Cash

Amount Tendered:

\$85.00

Amount Returned:

\$1.00

PAID IN FULL

Case: 95CC1-2015-CV-592 Linda Caldwell vs SSC Lebanon Operating Company LLC (et. al);

Amount Paid:

84.00

Debbie Moss

IN THE CIRCUIT COURT OF TENNESSEE FOR THE FIFTEENTH JUDICIAL DISTRICT AT LEBANON, WILSON COUNTY

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased, and on behalf of the wrongful death beneficiaries of Sarah Katherine Rodgers

follows:

Plaintiff,

COMES NOW Plaintiff, Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased against SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC, Defendants, and for this cause of action would show as

PARTIES

- 1. Linda Caldwell is the daughter of Sarah Katherine Rodgers and brings this action as Next of Kin of Sarah Katherine Rodgers, Deceased, and on behalf of the wrongful death beneficiaries of Sarah Katherine Rodgers.
- 2. Upon information and belief, Sarah Katherine Rodgers was a resident of Lebanon Health and Rehabilitation Center, a facility owned, operated and/or managed by Defendants located at 731 Castle Heights Court, Lebanon, Tennessee, from 2011 until on or

about October 20, 2014, when she was discharged to University Medical Center. Sarah Katherine Rodgers died on November 6, 2014 at the Pavilion in Lebanon, Tennessee.

- 3. At all times mentioned herein, Sarah Katherine Rodgers was unable to attend to her own affairs, was disabled, and incompetent within the meaning of Tenn. Code Ann. § 28-1-106.
- 4. The foregoing savings statute tolled the limitations period for Sarah Katherine Rodgers's claims against Lebanon Health and Rehabilitation Center and all of her claims are timely filed.
- 5. Nursing Home Defendant SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center is a Delaware limited liability company that at all times material to this action was the "licensee" authorized to operate a nursing facility under the name of Lebanon Health and Rehabilitation Center, Lebanon, Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center may be served with process through its registered agent, C T Corporation System, Suite 2021, 800 S Gay Street, Knoxville, TN 37929.
- 6. Nursing Home Defendant SMV Lebanon, LLC is a Delaware limited liability company that at times material to this lawsuit was engaged in business in Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant SMV Lebanon, LLC may be served with process through its registered agent, VCorp Services, LLC, 15439 Old

Hickory Blvd., Nashville, TN 37211-6272.

- Nursing Home Defendant Sava SeniorCare, LLC is a foreign limited liability company that at times material to this lawsuit was engaged in business in Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant Sava SeniorCare, LLC may be served with process through its registered agent, The Corporation Trust Company, Corporation Trust Center, 1209 Orange St., Wilmington, DE 19801.
- 8. Nursing Home Defendant Sava SeniorCare Administrative Services, LLC is a foreign limited liability company that at times material to this lawsuit was engaged in business in Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant Sava SeniorCare Administrative Services, LLC may be served with process through its registered agent, The Corporation Trust Company, Corporation Trust Center, 1209 Orange St., Wilmington, DE 19801.
- 9. Nursing Home Defendant Sava SeniorCare Consulting, LLC is a foreign limited liability company that at times material to this lawsuit was engaged in business in Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant Sava SeniorCare Consulting, LLC may be served with process through its registered agent, The Corporation Trust Company, Corporation Trust Center, 1209 Orange St., Wilmington, DE

19801.

- 10. Nursing Home Defendant Tennessee HoldCo, LLC is a foreign limited liability company that at times material to this lawsuit was engaged in business in Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant Tennessee HoldCo, LLC may be served with process through its registered agent, The Corporation Trust Company, Corporation Trust Center, 1209 Orange St., Wilmington, DE 19801.
- 11. Nursing Home Defendant SSC Submaster Holdings, LLC is a foreign limited liability company that at times material to this lawsuit was engaged in business in Tennessee. The causes of action made the basis of this suit arise out of such business conducted by said Nursing Home Defendant in the ownership, operation, management, and/or control of Lebanon Health and Rehabilitation Center. Nursing Home Defendant SSC Submaster Holdings, LLC may be served with process through its registered agent, The Corporation Trust Company, Corporation Trust Center, 1209 Orange St., Wilmington, DE 19801.
- 12. Whenever the term "Nursing Home Defendants" is utilized within this suit, such term collectively refers to and includes SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC.
- 13. Whenever in this suit it is alleged that Defendants did any act or thing or failed to do any act or things, it is meant that the officers, agents, or employees of the designated corporations respectively performed, participated in, or failed to perform such acts or

things while in the course and scope of their employment and/or agency relationship with said Defendants.

NATURE OF NURSING HOME DEFENDANTS' LIABILITY

ALTER EGO: Nursing Home Defendants, SSC Lebanon Operating Company, 14. LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC, were mere conduits through which Nursing Home Defendant, Sava SeniorCare, LLC, did business. The management and the operations of SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC were so assimilated within the parent, Sava SeniorCare, LLC, to the extent that the aforementioned subsidiaries were simply a name through which the parent, Sava SeniorCare, LLC, conducted its business. Moreover, Sava SeniorCare, LLC, represented to the public that its subsidiaries, SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC, were part of one single economic enterprise known as Sava SeniorCare, LLC. Said parent corporation completely dominated and controlled the business affairs of its subsidiaries insomuch as SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC, were organized and operated as mere tools of Sava SeniorCare, LLC.

- 17. AGENCY: In the alternative, at all times material to this suit, Nursing Home Defendants, SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee HoldCo, LLC; and SSC Submaster Holdings, LLC acted as agents of Nursing Home Defendant, Sava SeniorCare, LLC. As such, Nursing Home Defendant, Sava SeniorCare, LLC, ratified or authorized the acts or omissions of the other Nursing Home Defendants.
- Defendants are found to be separate corporate entities and would not be liable for the acts of each other under theories that allow looking beyond the corporate fiction, each Corporate Defendant remains liable for the acts of the others because Nursing Home Defendants operated their business as a joint enterprise. Nursing Home Defendants engaged in a joint venture and acted in concert in the operation, management, and maintenance of Lebanon Health and Rehabilitation Center. These entities entered into an agreement with the common purpose of operating, managing, and maintaining Lebanon Health and Rehabilitation Center. These entities had an equal right to control their venture as a whole, as well as to control the operation and management of the subject facility.

FACTS

19. Upon information and belief, Sarah Katherine Rodgers was a resident at Lebanon Health and Rehabilitation Center, a skilled nursing facility located at 731 Castle Heights Court, Lebanon, Tennessee, from 2011 until on or about October 20, 2014, when she was discharged to University Medical Center. Sarah Katherine Rodgers died on November 8, 2014 at the Pavilion in Lebanon, Tennessee.

- 20. At all times mentioned hereto, Sarah Katherine Rodgers was of unsound mind and unable to attend to her affairs or care for herself throughout her residency at Lebanon Health and Rehabilitation Center.
- 21. While in the care of Nursing Home Defendants, Sarah Katherine Rodgers suffered injuries and harm which include, but are not limited to, the following:
 - Development and worsening of wounds to the sacrum/ coccyx/ buttocks;
 - · Infections, including UTIs, and proteus mirabilis;
 - Malnutrition;
 - Poor hygiene;
 - Severe pain; and
 - Untimely Death
- 22. As a result of these injuries, Sarah Katherine Rodgers required medical attention and her overall health deteriorated, causing unnecessary physical suffering and mental anguish, and her death.
- 23. The injuries described in this Complaint are a direct and proximate result of the acts or omissions set forth herein, singularly or in combination.

VENUE

24. The injuries made the basis of this lawsuit were products of the corporate and financial policies designed, formulated, and implemented by Nursing Home Defendants at Lebanon Health and Rehabilitation Center. Venue for this action lies in Wilson County, Tennessee.

CAUSES OF ACTION AGAINST NURSING HOME DEFENDANTS

NEGLIGENCE PURSUANT TO THE TENNESSEE HEALTH CARE LIABILITY ACT, TENN. CODE ANN. §§ 29-26-101, ET SEQ.

- October 1, 2011. Plaintiff contends, however, that T.C.A. § 29-26-101 is unconstitutional, as amended, under the Constitutions of the State of Tennessee and the United States and violates due process, the separation of powers doctrine, and the inherent authority of the courts to protect the integrity of the proceedings and the rights of the litigants. The assertion of a cause of action under this statute should not be deemed a waiver of Plaintiff's right to challenge the constitutionality of the statute.
- 26. Plaintiff re-alleges and incorporates all prior allegations in paragraphs 1-24 as if fully set forth herein.
- 27. Plaintiff has complied with Tenn. Code Ann. § 29-26-121(a) by providing notice of the claim by certified mail to all Defendants at both the address listed for each defendant on the Tennessee Department of Health website and at the defendant's current business address, all of which is evidenced by the Affidavit(s) of M. Chad Trammell attached as Exhibit "A" and incorporated by reference, verifying notice was sent by certified mail to Defendants on August 18, 2015. A copy of each notice and each Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing, are attached to the Affidavit(s) and establish that the specified notices were timely mailed by certified mail, return receipt requested. The requirements of T.C.A. § 29-26-121(a) have been satisfied.
- 28. Plaintiff complied timely with the notice requirements of T.C.A. § 29-26-121(a) by giving notice and providing the documents required by T.C.A. § 29-26-121(a) to all Defendants more than 60 days before the filing of this Complaint.

- 29. Plaintiff has complied with Tenn. Code Ann. § 29-26-122 by filing the required Certificate of Good Faith with this Complaint, attached as Exhibit "B" and incorporated by reference.
- 30. Nursing Home Defendants are "health care providers" within the meaning of T.C.A. § 29-26-101 and owed a duty to Sarah Katherine Rodgers to provide her healthcare services in a safe and beneficial manner.
- 31. Nursing Home Defendants breached their duties owed to Sarah Katherine Rodgers, thereby causing Sarah Katherine Rodgers to be injured as set forth in this Complaint. Such breaches by Nursing Home Defendants include, but are not limited to, the following:
 - (a) Failure to provide sufficient numbers of certified nursing assistants to meet the custodial needs of Sarah Katherine Rodgers, including, but not limited to, food, water, baths, showers, grooming, incontinent care, personal attention and care to her skin, feet, and nails, oral hygiene, and haircuts;
 - (b) Failure to administer the facility in such a manner so as to provide the facility with adequate resources to ensure sufficient non-medical (CNA) staffing and supplies, such as diapers, linens, and towels, to care for all residents, including Sarah Katherine Rodgers;
 - (c) Failure to provide sufficient number of non-licensed staff to follow Sarah Katherine Rodgers' care plans and to prevent Sarah Katherine Rodgers' needs from being ignored;
 - (d) Failure to provide adequate supervision and oversight to non-licensed personnel to ensure that Sarah Katherine Rodgers received adequate and proper custodial care;
 - (e) Failure to provide adequate overall custodial (non-medical) care;

- (f) Failure to provide adequate and appropriately trained non-licensed staff and supervision to such personnel so as to ensure that Sarah Katherine Rodgers received adequate and proper custodial care, adequate hydration, and warm and palatable meals;
- (g) Failure to adopt adequate guidelines, policies and procedures for documenting, maintaining files, investigating and responding to any complaint regarding the quantity of resident care, the quality of resident care, or misconduct by Nursing Home Defendants' employees, irrespective of whether such complaint derived from a state or federal survey agency, resident of said facility, an employee of said facility or any interested person (with regard to non-medical complaints);
- (h) Failure by the members of the governing body of the nursing home to discharge their legal and lawful obligation by:
 - (1) ensuring that the rules and regulations designed to protect the health and safety of the patients, such as Sarah Katherine Rodgers as promulgated by the Tennessee Legislature and corresponding regulations implemented expressly pursuant thereto by the Tennessee Department of Health and its agents, including the Division of Health Care Facilities, were consistently complied with on an ongoing basis;
 - (2) ensuring that the resident care policies for the facility were consistently in compliance on an ongoing basis; and
 - (3) responsibly ensuring that appropriate corrective measures were implemented to correct problems concerning inadequate resident care (non-medical).

- (i) Failure of non-licensed personnel to maintain records in accordance with accepted standards and practices that are complete, accurately documented, readily accessible, and systematically organized with respect to Sarah Katherine Rodgers;
- (j) Failure to provide basic and necessary non-medical care and supervision during Sarah Katherine Rodgers' residency;
- (k) Failure to protect Sarah Katherine Rodgers from abuse and neglect during her residency;
- (1) Failure to treat Sarah Katherine Rodgers with kindness and respect;
- (m) Failure of high managerial agents and corporate officers to adequately hire, train, supervise, and retain the administrator and other staff so as to assure that Sarah Katherine Rodgers received care in accordance with Nursing Home Defendants' policies and procedures;
- (n) Making false, misleading, and deceptive representations as to the quality of care, treatment and services provided by the facility to their residents, including Sarah Katherine Rodgers;
- (o) Failure to provide and ensure adequate nursing care plans, including necessary revisions, based on the needs of Sarah Katherine Rodgers;
- (p) Failure to develop and implement an adequate nursing care plan for Sarah Katherine Rodgers that was followed by nursing personnel;
- (q) Failure to take reasonable steps to prevent, eliminate, and correct medical deficiencies and problems in resident care;
- (r) Failure to provide care, treatment, and medication to Sarah Katherine Rodgers in accordance with physician's orders;

- (s) Failure to properly and timely notify Sarah Katherine Rodgers' attending physician and/or nurse practitioners of significant changes in her physical condition;
- (t) Failure to adequately assess, monitor, and address Sarah Katherine Rodgers' nutritional status in order to prevent weight loss;
- (u) Failure to provide a safe environment for Sarah Katherine Rodgers;
- (v) Failure to properly assess Sarah Katherine Rodgers in order to prevent infections;
- (w) Failure to adequately and appropriately monitor Sarah Katherine Rodgers and recognize significant changes in her health status;
- (x) Failure to adequately assess, monitor and treat Sarah Katherine Rodgers in order to prevent the development and worsening of pressure sores; and
- (y) Failure to provide treatment for persistent, unresolved problems related to the care and physical condition of Sarah Katherine Rodgers, resulting in her unnecessary pain, agony, and suffering.
- 32. Nursing Home Defendants' conduct in breaching the duties they owed Sarah Katherine Rodgers was negligent, grossly negligent, willful, wanton, malicious, reckless, and/or intentional.
- 33. As a direct and proximate result of such negligent, grossly negligent, willful, wanton, reckless, malicious, and/or intentional conduct, Sarah Katherine Rodgers was injured, for which Plaintiff asserts a claim for judgment for all compensatory and punitive damages against Nursing Home Defendants, including, but not limited to medical expenses, pain and suffering, mental anguish, disability, and humiliation in an amount to be determined by the jury, plus costs and all other relief to which Plaintiff is entitled by law.

SURVIVAL AND WRONGFUL DEATH CLAIM

- 34. Plaintiff re-alleges and incorporates the allegations in paragraphs 1-33 as if fully set forth herein.
- 35. As a direct and proximate result of the acts or omissions of Defendants as set forth above, Sarah Katherine Rodgers suffered mental anguish, pain and suffering, and physical injuries which include, but are not limited to, those described herein, including death.
- 36. As a further direct and proximate result of Defendants' conduct, Sarah Katherine Rodgers required medical attention and hospitalization, and incurred liability to pay reasonable and necessary charges for such.
- 37. As a direct, natural and proximate result of the acts or omissions of Defendants as set forth above, Sarah Katherine Rodgers died on November 6, 2014, thereby incurring reasonable and necessary charges for funeral and related expenses.
- As a direct and proximate result of the previously alleged conduct, all of which was negligent, grossly negligent, willful and wanton, outrageous, reckless, malicious, and/or intentional, Sarah Katherine Rodgers endured pain, suffering, and death. Indeed, Sarah Katherine Rodgers suffered personal injury including excruciating pain and suffering, mental anguish, emotional distress, and humiliation, which includes, but is not limited to, that described herein. Additionally, Sarah Katherine Rodgers's family has suffered more than the normal grief on losing the life of their loved one and accordingly seeks damages for loss of attention, guidance, care, protection, companionship, cooperation, affection, and love. Accordingly, Plaintiff is entitled to recover against Defendants compensatory and punitive damages based on the foregoing.

DAMAGES

- 39. Plaintiff re-alleges and incorporates the allegations in paragraphs 1-38 as if fully set forth herein.
- As a direct and proximate result of the acts and omissions of all Nursing Home Defendants as set out above, Sarah Katherine Rodgers suffered injuries including, but not limited to, those described herein. As a result, Sarah Katherine Rodgers incurred significant medical expenses and suffered embarrassment and physical impairment and pain and suffering.
- 41. Plaintiff seeks punitive and compensatory damages against Nursing Home Defendants in an amount to be determined by the jury, plus costs and all other relief to which Plaintiff is entitled by law.
- 42. To the extent T.C.A. §§ 29-39-101, et seq., is asserted by Nursing Home Defendants or deemed applicable to the present case or controversy, Plaintiff affirmatively avers that these statutory provisions are unconstitutional.

The Constitution of the State of Tennessee provides for:

- (1) Right to Trial by Jury.
 - [T]he right of trial by jury shall remain inviolate
 - Tennessee Constitution, Art. 1, Sec. 6.
 - (2) Open Courts.
 - [A]ll courts shall be open; and every man, for an injury done him in his lands, goods, person or reputation, shall have remedy by due course of law, and right and justice administered without sale, denial, or delay.
 - Tennessee Constitution, Art. 1, Sec. 17.
 - (3) Separation of Powers.

The powers of the government shall be divided into three distinct departments: legislative, executive and judicial.

Tennessee Constitution, Art. 2, Sec. 1.

No person or persons belonging to one of these departments shall exercise any of the powers properly belonging to either of the others, except in the cases herein directed or permitted.

Tennessee Constitution, Art. 2, Sec. 2.

The Constitution of the United States provides for:

(1) Right to Trial by Jury.

In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law.

United States Constitution, Amendment VII.

(2) Due Process and Equal Protection.

...No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; ...without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws ...

United States Constitution, Amendment XIV.

43. Plaintiff asserts that Tenn. Code Ann. §§ 29-39-101, et seq., violates the Constitutions of the State of Tennessee and the United States by affecting the right to trial by jury, open courts, separation of powers, equal protection, and due process.

REQUEST FOR TRIAL BY JURY

44. Plaintiff demands a trial by jury of twelve (12) on all issues herein set forth.

PRAYER FOR RELIEF

45. Pursuant to Tennessee Rules of Civil Procedure, Plaintiff demands that all issues of fact in this case be tried by a jury.

RELIEF SOUGHT

WHEREFORE, Plaintiff prays for judgment against Defendants, as follows:

- 1) For damages to be determined by the jury, in an amount to compensate adequately Plaintiff for all the injuries and damages sustained;
 - 2) For all general and special damages caused by the alleged conduct of Defendants;
 - 3) For the costs of litigating this case;
- 4) For punitive damages sufficient to punish Defendants for their egregious conduct and to deter Defendants and others from repeating such atrocities; and
- 5) For all other relief to which Plaintiffs are entitled by Tennessee law, including attorneys' fees, as specifically provided for by T.C.A. § 71-6-101, et seq. and T.C.A. § 47-14-101, et seq.

WHEREFORE, Plaintiff respectfully reserves her right to amend this Complaint to conform to the evidence as it develops.

Respectfully Submitted,

TRAMMELL PIAZZA LAW FIRM, PLLC

M. Chad Trampaell

TN BPR# 021146 418 North State Line Avenue Texarkana, Arkansas 71854 Telephone: 870.779.1860 Facsimile: 870.779.1861

And

Daniel L. Clayton, BPR #12600 KINNARD, CLAYTON & BEVERIDGE 127 Woodmont Boulevard Nashville, Tennessee 37205 (615) 297-1007 (615) 297-1505 FAX

Attorneys for Plaintiff

STATE OF TENNESSEE CIVIL SUMMONS

Case Number

Utily TU XIVE

2015-CV-592

page 1 of 1

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

| Served On: | SSC Submaster Holdings, LLC c/o The Corporation Trust Company, Corporation Trust Center |
|---|--|
| | 1209 Orange St., Wilmington, DE 19801 |
| within thirty (30) days copy to the plaintiff's a | ned to defend a civil action filed against you in The Circuit Court, Tipton County, Tennessee. Your defense must be made from the date this summons is served upon you. You are directed to file your defense with the clerk of the court and send a ttorney at the address listed below. If you fail to defend this action by the below date, judgment by default may be rendered of sought in the complaint. |
| Issued: Decom | ber 2, 2015 Clerk/Deputy Clerk |
| Attorney for Plaintiff: | M. Chad Trammell 418 North State Line, Texarkana, AR 71854 |
| from execution or seizu listed in TCA § 26-2-36 written list, under oath, you thereafter as neces issued prior to the filin wearing apparel (clothin Bible, and school book right or how to exercise | NOTICE OF PERSONAL PROPERTY EXEMPTION T(S): Tennessee law provides a ten thousand dollar (\$10,000) personal property exemption as well as a homestead exemption are to satisfy a judgment. The amount of the homestead exemption depends upon your age and the other factors which are on the judgment should be entered against you in this action and you wish to claim property as exempt, you must file a file of the items you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by sary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment ag of the list. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary ing) for your self and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family so. Should any of these items be seized you would have the right to recover them. If you do not understand your exemption to it, you may wish to seek the counsel of a lawyer. Please state file number on list. Clerk, County |
| | CERTIFICATION (IF APPLICABLE) |
| Ι, | Clerk of County do certify this to be a true and correct copy of issued in this case. |
| the original summons i | issued in this case. |
| Date: | Clerk / Deputy Clerk |
| OFFICER'S RET | TURN: Please execute this summons and make your return within ninety (90) days of issuance as provided by law. |
| I certify that I have ser | ved this summons together with the complaint as follows: |
| Date: | Byt |
| Dates | Officer, Title |
| RETURN ON SE | RVICE OF SUMMONS BY MAIL: I hereby certify and return that on, I sent postage |
| prepaid, by registered | return receipt mail or certified return receipt mail, a certified copy of the summons and a copy of the complaint in the above |
| styled case, to the defe | I received the return receipt, which had been signed by |
| | on The return receipt is attached to this original summons to be filed by the Court Clerk. |
| Date: | Notary Public / Deputy Clerk (Comm. Expires) |
| Signature of Plaintiff | Plaintiff's Attorney (or Person Authorized to Serve Process) (Attach return receipt on back) |

ADA: If you need assistance or accommodations because of a disability, please call ______, ADA Coordinator, at () ______

STATE OF TENNESSEE CIVIL SUMMONS

Case Number 2015-CV-598

UTIN IU. KIVO

page 1 of 1

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

| | HoldCo, LLC c/o The Corporation Trust Company, Corporation Trust Center |
|--|--|
| | e St., Wilmington, DE 19801 |
| within thinty (20) dove from the date this summ | W M M |
| Attorney for Plaintiff: M. Chad Trammell 418 North State Lin | e, Texarkana, AR 71854 |
| TO THE DEFENDANT(S): Tennessee law p from execution or seizure to satisfy a judgmen listed in TCA § 26-2-301. If a judgment shou written list, under oath, of the items you wish you thereafter as necessary; however, unless i issued prior to the filing of the list. Certain its wearing apparel (clothing) for your self and you bible, and school books. Should any of these right or how to exercise it, you may wish to see | ICE OF PERSONAL PROPERTY EXEMPTION revides a ten thousand dollar (\$10,000) personal property exemption as well as a homestead exemption. The amount of the homestead exemption depends upon your age and the other factors which are done entered against you in this action and you wish to claim property as exempt, you must file a co-claim as exempt with the clerk of the court. The list may be filed at any time and may be changed is filed before the judgment becomes final, it will not be effective as to any execution or garnishment ms are automatically exempt by law and do not need to be listed; these include items of necessary our family and trunks or other receptacles necessary to contain such apparel, family portraits, the familtems be seized you would have the right to recover them. If you do not understand your exemption ek the counsel of a lawyer. Please state file number on list. |
| Mail list to | Clerk,County |
| | CERTIFICATION (IF APPLICABLE) |
| I, | |
| Date: | Clerk / Deputy Clerk |
| OFFICER'S RETURN: Please execut | this summons and make your return within ninety (90) days of issuance as provided by law. |
| I certify that I have served this summons toge | her with the complaint as follows: |
| | |
| Date:—— | By:Officer, Title |
| RETURN ON SERVICE OF SUM prepaid, by registered return receipt mail or c styled case, to the defendant | |
| RETURN ON SERVICE OF SUM prepaid, by registered return receipt mail or c styled case, to the defendant | MONS BY MAIL: I hereby certify and return that onI sent postage triffied return receipt mail, a certified copy of the summons and a copy of the complaint in the aboveOnI received the return receipt, which had been signed by The return receipt is attached to this original summons to be filed by the Court Clerk. |

STATE OF TENNESSEE CIVIL SUMMONS

Case Number

WAIN IN. KING

2015-CV-592

page 1 of 1

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

| Served On: | ava SeniorCare Consulting, LLC c/o The Corporation Trust Company, Corporation Trust Center |
|---|--|
| 1 | 209 Orange St., Wilmington, DE 19801 |
| within thirty (30) days from the decopy to the plaintiff's attorney at against you for the relief sought is | end a civil action filed against you in The Circuit Court, Tipton County, Tennessee. Your defense must be made ate this summons is served upon you. You are directed to file your defense with the clerk of the court and send a the address listed below. If you fail to defend this action by the below date, judgment by default may be rendered in the complaint. |
| Issued: Decompos 2, | 205 Clerk Deputy Clerk |
| Attorney for Plaintiff: M. Cha 418 No. | nd Trammell orth State Line, Texarkana, AR 71854 |
| from execution or seizure to satis listed in TCA § 26-2-301. If a ju written list, under oath, of the iter you thereafter as necessary; howe issued prior to the filing of the list wearing apparel (clothing) for you | NOTICE OF PERSONAL PROPERTY EXEMPTION messee law provides a ten thousand dollar (\$10,000) personal property exemption as well as a homestead exemption fy a judgment. The amount of the homestead exemption depends upon your age and the other factors which are degment should be entered against you in this action and you wish to claim property as exempt, you must file a may you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by ever, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment at. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary our self and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family any of these items be seized you would have the right to recover them. If you do not understand your exemption may wish to seek the counsel of a lawyer. Please state file number on list. |
| | Clerk,County |
| | |
| | CERTIFICATION (IF APPLICABLE) |
| I, the original summons issued in the | Clerk of County do certify this to be a true and correct copy of his case. |
| | |
| Date: | Clerk / Deputy Clerk |
| OFFICER'S RETURN: 1 | Please execute this summons and make your return within ninety (90) days of issuance as provided by law. |
| I certify that I have served this su | ammons together with the complaint as follows: |
| | |
| | ● |
| Date:- | Officer, Title |
| DECLIDA ON CEDUICE | OF SUMMONS BY MAIL: I hereby certify and return that on I sent postage |
| | |
| prepaid, by registered return rece | eipt mail or certified return receipt mail, a certified copy of the summons and a copy of the complaint in the above On I received the return receipt, which had been signed by |
| styled case, to the defendant | The return receipt is attached to this original summons to be filed by the Court Clerk. |
| on | The foldin feeding is attached to this original substitute in |
| Date: | Notary Public / Deputy Clerk (Comm. Expires) |
| Signature of Plaintiff | Plaintiff's Attorney (or Person Authorized to Serve Process) (Attach return receipt on back) |

ADA: If you need assistance or accommodations because of a disability, please call ______, ADA Coordinator, at () ______

STATE OF TENNESSEE **CIVIL SUMMONS**

WHY TO YEIVE

Case Number

8015-CV-598

page 1 of 1

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

| Served On: | Sava SeniorCare Administrativ | re Services, LLC | c/o The Corporation Trust Company, Corporati |
|--|--|--|---|
| | Trust Center, 1209 Orange St | ., Wilmington, DE | 19801 |
| within thirty (30) days from | the date this summons is served upon you ey at the address listed below. If you fail ight in the complaint, | You are directed to to defend this action | Tipton County, Tennessee. Your defense must be made of file your defense with the clerk of the court and send a by the below date, judgment by default may be rendered Deputy Clerk |
| Attorney for Plaintiff: M | . Chad Trammell 8 North State Line, Texarkana, AR 7185 | | |
| from execution or seizure to listed in TCA § 26-2-301. It written list, under oath, of th you thereafter as necessary; issued prior to the filing of the wearing apparel (clothing) for Bible, and school books. She right or how to exercise it, y | satisfy a judgment. The amount of the h f a judgment should be entered against you eitems you wish to claim as exempt with however, unless it is filed before the judghe list. Certain items are automatically error your self and your family and trunks or yould any of these items be seized you woou may wish to seek the counsel of a law | dollar (\$10,000) person comestead exemption ou in this action and y in the clerk of the cour gment becomes final, exempt by law and do rother receptacles neould have the right to yer. Please state file | onal property exemption as well as a homestead exemption depends upon your age and the other factors which are you wish to claim property as exempt, you must file a ret. The list may be filed at any time and may be changed it will not be effective as to any execution or garnishmen not need to be listed; these include items of necessary to contain such apparel, family portraits, the family recover them. If you do not understand your exemption number on list. |
| Mail list to | ,CI | lerk, | County |
| Date:OFFICER'S RETUR | Clerk of Clerk of Clerk / I N: Please execute this summons and ma | Deputy Clerk ke your return within | County do certify this to be a true and correct copy of a ninety (90) days of issuance as provided by law. |
| I certify that I have served the | his summons together with the complaint | By: Officer, Tit | tle |
| prepaid, by registered return styled case, to the defendant | n receipt mail or certified return receipt m | nail, a certified copy o | d return that on, I sent postage of the summons and a copy of the complaint in the above received the return receipt, which had been signed by a original summons to be filed by the Court Clerk. |
| Date: | | Notary Public / Dep | outy Clerk (Comm. Expires) |
| Signature of Plaintiff | (Attach re | Plaintiff's Attorney | (or Person Authorized to Serve Process) |
| ADA: If you need assistance | e or accommodations because of a disabi | | , ADA Coordinator, at () |

STATE OF TENNESSEE CIVIL SUMMONS

Case Number

Uttily 10. 10.

2015-CV-592

page 1 of 1

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

| Served On: | Sava SeniorCare, LLC c/o The Corporation Trust Company, Corporation Trust Center |
|--|--|
| | 1209 Orange St., Wilmington, DE 19801 |
| within thirty (30) days from | I to defend a civil action filed against you in The Circuit Court, Tipton County, Tennessee. Your defense must be made in the date this summons is served upon you. You are directed to file your defense with the clerk of the court and send a mey at the address listed below. If you fail to defend this action by the below date, judgment by default may be rendered ought in the complaint. |
| Issued: Olcomo | Clerk Deputy Clerk |
| Attorney for Plaintiff: | M. Chad Trammell 418 North State Line, Texarkana, AR 71854 |
| from execution or seizure listed in TCA § 26-2-301. written list, under oath, of you thereafter as necessar issued prior to the filing o wearing apparel (clothing Bible, and school books. right or how to exercise it. | NOTICE OF PERSONAL PROPERTY EXEMPTION 3): Tennessee law provides a ten thousand dollar (\$10,000) personal property exemption as well as a homestead exemption to satisfy a judgment. The amount of the homestead exemption depends upon your age and the other factors which are If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a the items you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by the items you wish to claim as exempt becomes final, it will not be effective as to any execution or garnishment find list. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary of for your self and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Should any of these items be seized you would have the right to recover them. If you do not understand your exemption you may wish to seek the counsel of a lawyer. Please state file number on list. Clerk. County |
| | CERTIFICATION (IF APPLICABLE) |
| ī | Clerk of County do certify this to be a true and correct copy of |
| the original summons issu | Clerk of County do certify this to be a true and correct copy of the in this case. |
| Date: | |
| | Clerk / Deputy Clerk |
| | RN: Please execute this summons and make your return within ninety (90) days of issuance as provided by law. |
| I certify that I have served | this summons together with the complaint as follows: |
| | |
| B | Ву: |
| Date:- | Officer, Title |
| DETURN ON SERV | VICE OF SUMMONS BY MAIL: I hereby certify and return that onI sent postage |
| | urn receipt mail or certified return receipt mail, a certified copy of the summons and a copy of the complaint in the above |
| otylod asso to the defende | ant I received the return receipt, which had been signed by |
| styled case, to the defenda | n The return receipt is attached to this original summons to be filed by the Court Clerk. |
| | • |
| Date: | Notary Public / Deputy Clerk (Comm. Expires) |
| | Notary Fubric / Deputy Clerk (Comm. Expires |
| Signature of Plaintiff | Plaintiff's Attorney (or Person Authorized to Serve Process) (Attach return receipt on back) |

ADA: If you need assistance or accommodations because of a disability, please call ______, ADA Coordinator, at () ______

STATE OF TENNESSEE **CIVIL SUMMONS**

Case Number

ULTIVU TU LI VE

2015-CV-592

page 1 of 1

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

| Served On: | SMV Lebanon, LLC c/o VCorp Services, LLC |
|--|---|
| | 15439 Old Hickory Blvd., Nashville, TN 37211-6272 |
| with in thinty (20) down from | I to defend a civil action filed against you in The Circuit Court, Tipton County, Tennessee. Your defense must be made me the date this summons is served upon you. You are directed to file your defense with the clerk of the court and send a rney at the address listed below. If you fail to defend this action by the below date, judgment by default may be rendered ought in the complaint. |
| Issued: DlClmbE | Clerk Deputy Clerk |
| Attorney for Plaintiff: | M. Chad Trammell 418 North State Line, Texarkana, AR 71854 |
| from execution or seizure listed in TCA § 26-2-301. written list, under oath, of you thereafter as necessar issued prior to the filing o wearing apparel (clothing Bible, and school books. right or how to exercise it | NOTICE OF PERSONAL PROPERTY EXEMPTION S): Tennessee law provides a ten thousand dollar (\$10,000) personal property exemption as well as a homestead exemption to satisfy a judgment. The amount of the homestead exemption depends upon your age and the other factors which are If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a the items you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by y, however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment f the list. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary of for your self and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Should any of these items be seized you would have the right to recover them. If you do not understand your exemption, you may wish to seek the counsel of a lawyer. Please state file number on list. |
| Mail list to | Clerk,County |
| | CERTIFICATION (IF APPLICABLE) |
| I, the original summons issu Date: | Clerk of County do certify this to be a true and correct copy of ued in this case. |
| OFFICED'S DETII | Clerk / Deputy Clerk RN: Please execute this summons and make your return within ninety (90) days of issuance as provided by law. |
| | it this summons together with the complaint as follows: |
| Date:- | By:———————————————————————————————————— |
| RETURN ON SER | VICE OF SUMMONS BY MAIL: I hereby certify and return that on, I sent postage |
| styled case, to the defend | ant On I received the return receipt, which had been signed by |
| | The return receipt is attached to this original summons to be filed by the Court Clerk. |
| Date: | Notary Public / Deputy Clerk (Comm. Expires) |
| Signature of Plaintiff | Plaintiff's Attorney (or Person Authorized to Serve Process) (Attach return receipt on back) |

ADA: If you need assistance or accommodations because of a disability, please call ______, ADA Coordinator, at () _____

STATE OF TENNESSEE CIVIL SUMMONS

Case Number

WIND IN KIND

2015-W-592

page 1 of 1

Linda Caldwell, as Next of Kin of Sarah Katherine Rodgers, Deceased v. SSC Lebanon Operating Company, LLC, et al

| Served On: | SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o |
|---|---|
| | CT Corporation, Suite 2021, 800 Gay St., Knoxville, TN 37929-9710 |
| within thirty (30) days from th copy to the plaintiff's attorney against you for the relief sougl | defend a civil action filed against you in The Circuit Court, Tipton County, Tennessee. Your defense must be made e date this summons is served upon you. You are directed to file your defense with the clerk of the court and send a at the address listed below. If you fail to defend this action by the below date, judgment by default may be rendered at in the complaint. |
| Issued: DUMDEX | 2,2015 Clerk Deputy Clerk |
| Attorney for Plaintiff: M. 0 418 | Chad Trammell North State Line, Texarkana, AR 71854 |
| from execution or seizure to sa listed in TCA § 26-2-301. If a written list, under oath, of the you thereafter as necessary; he issued prior to the filing of the wearing apparel (clothing) for | NOTICE OF PERSONAL PROPERTY EXEMPTION Tennessee law provides a ten thousand dollar (\$10,000) personal property exemption as well as a homestead exemption disfy a judgment. The amount of the homestead exemption depends upon your age and the other factors which are judgment should be entered against you in this action and you wish to claim property as exempt, you must file a items you wish to claim as exempt with the clerk of the court. The list may be filed at any time and may be changed by lowever, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment list. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary your self and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family ald any of these items be seized you would have the right to recover them. If you do not understand your exemption may wish to seek the counsel of a lawyer. Please state file number on list. |
| Mail list to | Clerk,County |
| | |
| | CERTIFICATION (IF APPLICABLE) County do certify this to be a true and correct copy of |
| I, the original summons issued i | Clerk of County do certify this to be a true and correct copy of m this case. |
| Date: | |
| | Clerk / Deputy Clerk |
| | : Please execute this summons and make your return within ninety (90) days of issuance as provided by law. |
| I certify that I have served thi | s summons together with the complaint as follows: |
| | |
| Date | By: |
| | Officer, Title |
| RETURN ON SERVICE | CE OF SUMMONS BY MAIL: I hereby certify and return that on, I sent postage |
| prepaid, by registered return | eccipt mail or certified return receipt mail, a certified copy of the summons and a copy of the complaint in the above |
| styled case, to the defendant | On I received the return receipt, which had been signed by |
| on | The return receipt is attached to this original summons to be filed by the Court Clerk. |
| Date: | Notary Public / Deputy Clerk (Comm. Expires) |
| Signature of Plaintiff | Plaintiff's Attorney (or Person Authorized to Serve Process) (Attach return receipt on back) |

ADA: If you need assistance or accommodations because of a disability, please call ______, ADA Coordinator, at () ______.

EXHIBIT

"A"



AFFIDAVIT OF PERSON MAILING NOTICE

| STATE OF ARKANSAS |) |
|-------------------|---|
| |) |
| COUNTY OF MILLER |) |

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

- 1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.
- 2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center, 731 Castle Heights Court Lebanon, TN 37087, as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letter.

Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

Exhibit 3, which is a HIPAA compliant medical authorization permitting SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center to obtain complete medical records from each other provider being sent a notice.

Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammel

Trammell Piazza Law*i*Firm, PLLC

TN BPR No. 21146

418 N. State Line Avenue Texarkana, AR 71854 Subscribed and sworn to before me this 24 day of November, 2015.

| Lilly Vusquer
| NOTARY PUBLIC

My commission expires: 3-28-22





418 N. State Line Ave. Texarkana, AR 71854 ph 870.779.1860 fx 870.779.1861 tf 888.989.1860

Melody H. Piazza

M. Chad Trammell

chad@trammellpiazza.com

Virginia C. Trammell

Of Counsel Brian G. Brooks Eric T. Bishop Kimberly Norris

Deborah Riordan

TrammellPiazza.com

August 18, 2015

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

RE:

Sarah Katherine Rodgers

Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

- (A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.
- B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.
- (C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.
- (D) A list of the name and address of all providers being sent this notice is attached to this notice.
- (E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv Enclosure

Provider List

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System Suite 2021 800 S Gay Street Knoxville, TN 37929

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346



SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

| AUTHORIZAT | ION FOR REI | LEASI | OF PROTECT | red healt | H INFORMATION (F | HI) |
|---|---|---|--|--|--|------------------|
| Section A: This section must | be completed for | all Auth | orizations | | - congression | |
| Patient/Plan Member Name: | | | Birth Date: Social Security No. (optional): | | | |
| Sarah Katherine Rodgers | | | 5-15-26 415-30-9090 | | | |
| Provider's/Health Plun's Name: | | | Recipient's Name: SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Cer | | | |
| Provider's/Health Plan's Address: | | | Address 1: | | | |
| | | | Address 2; | | Significant States of September 1 | |
| | | | City: | | State: 2 | ւյ՛ր։ |
| This authorization will expire a | on the following: (| Fill in th Event: | ne Date or the Event | but not both.) | | |
| Purpose of disclosure: Co | OMPLIANCE W | tth T.C | C.A. § 29-26-121 | | | |
| | | | of information to be | | | |
| is this request for psychotherar another authorization for other | oy notes? 🗖 Yes, items below. 🍂 | then this | is the only item you you may check as m | may request on t any items below | this authorization. You mus as you need. | t submit |
| Description: | flate(s): | Descrip | | Date(s) | Description: | Date(s) |
| MAII PHI in medical record Admission form Dictation reports Physician orders Intake/outtake Clinical Test Medication Sheets | All Dates Of Service | M Cath M Speci M Rhyd M Nursi M Frans | ative Information lab ial test/therapy tun Strips ing Information efer forms | All Dates Of Service Of Service All Dates Of Service All Dates Of Service All Dates Of OB nursing assess Postpartum flow sheet All Dates Other: diagnostic films Dother: | | and studies |
| acknowledge, and hereby concesults or AIDS information. | /7/// (Initial | i) ir nor | applicable, clieck in | contain Alcohol, ere, II | drug abuse, psychiatric, HIV | testing, HIV |
| L. I may refuse to sign this aut D. My treatment, payment, end I may revoke this authorizate revocation. Further details If the requester or receiver privacy regulations and may I understand that I may see I get a copy of this form after | rollment or eligibil tion at any time in may be found in is not a health pla v be redisclosed, and obtain a copy | lity for b writing the Notion or hea | enelis may not be e , but if I do, it will note of Privacy Practic lth care provider, the | e released inform | ation may no longer he prote | ected by federal |
| ection B: Is the request of Plf yes, the health plan or health | care provider mus | t comple | ete Section B, otherv | vise skip to Section | on C. | |
| Vill the recipient receive financ | cial or in-kind com | npensatio | on in exchange for u | sing or disclosing | this information? TYes t | 1 No |
| If yes, describe: | | | | | Name and Address of the Owner, where the Owner, which is the Owner, where the Owner, which is the Ow | |
| ection C: Signatures | | | | | | |
| have read the above and author | | | | | | |
| ignature of Parients lan Memb | 1/1/ | nt/Plan I | Member Representat | | Date: 7-31-15 | |
| Print Name of Patient/Plan Member's Representative: Refationship to Patient/Plan Member: Livida (coldwell Laughter | | | | Member: | | |

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: 415-30-9090 5-15-26 Sarah Recipient's Name: SSC Lebanon Operating Company, LLC Provider's/Health Plan's Name: d/b/a Lebanon Health and Rehabilitation Center Provider's/Health Plan's Address: Address I: Address 2: State: Zip: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: Date: 7/11/6 Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121 Description of information to be used or disclosed Is this request for psychotherapy notes? 🗆 Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. KNo, then you may check as many items below as you need. Date(s) Description: Date(s): Description: Date(s) Description: a Labor/delivery sum. □ Operative Information ri All PHI in medical record OB nursing assess ra Admission form □ Cath lab Li Special test/therapy D Postpartum flow sheet ra Dictation reports □ Itamized bill: n Physician orders u Rhytlim Strips a UB-92: LI Nursing Information Intake/outtake U Other: diagnostic films and studies Clinical Test □ Transfer forms D Other: □ ER Information I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, to 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I understand that:

3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.

4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🗆 Yes 🗆 No

If yes, describe:

Section C; Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Papent/Plan Member/Guardizh/Patient/Plan Member Representative:

Print Name of Patient/Play Member's Representative: Coldwell

Relationship to Patient/Plan Member;

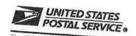
Revised 3/2003

Linda

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: Sarah Katherine Rodgers 415-30-9090 5-15-26 Recipient's Name: SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center Provider's/Health Plan's Address: Address 1: Address 2: City: State: Zip: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: 7/11/6 Event: Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121 Description of information to be used or disclosed is this request for psychotherapy notes? A Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

No, then you may check as many items below as you need. Description: Date(s): Description: Date(s) Description: Date(s) ra All PHI in medical record D Operative Information □ Labor/delivery sum. r Admission form Cath lab OB nursing assess 11 Special test/therapy LI Dictation reports □ Postpartum flow sheet. n Physician orders ta Rhytlun Strips □ Itemized bill: u lotake/outtake u Nursing Information u UB-92: Clinical Test Transfer forms U Other: diagnostic films and studies u Medication Sheets □ ER Information D Other: I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ______ (Initial) If not applicable, check here. u 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🛛 Yes 🗖 No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Powent/lan Member/Guardizo/Patient/Plan Member Representative: Print Name of Patient/Play Member's Representative: Relationship to Patient/Plan Member: Linda

Revised 3/2003



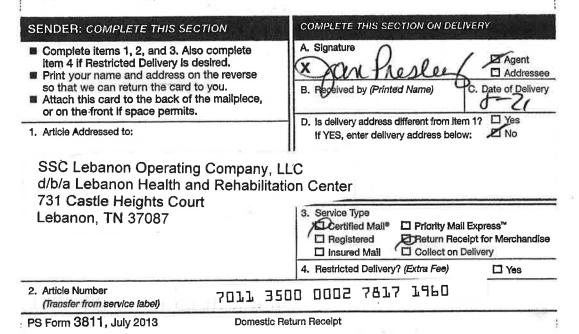
This Certificate of Mailing
This form may be used for domestic and international mail

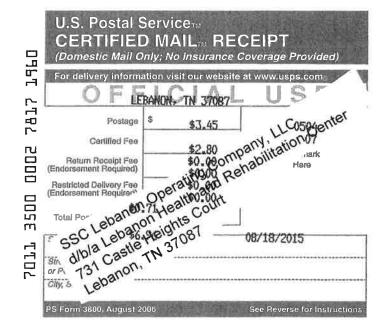
From:

Certificate Of Mailing
This form may be used for domestic and international mail Trammell Piazza Law Firm, PLLC 418 North State Line Ave. Texarkana, AR 71854

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Ce 731 Castle Heights Court Lebanon, TN 37087

PS Form 3817, April 2007 PSN 7530-02-000-9065





AFFIDAVIT OF PERSON MAILING NOTICE

| STATE OF ARKANSAS |) |
|-------------------|---|
| |) |
| COUNTY OF MILLER |) |

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

- 1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.
- 2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center, 1 Ravinia Drive Suite 1500 Atlanta, GA 30346, as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letter.

Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

Exhibit 3, which is a HIPAA compliant medical authorization permitting SSC Lebanon Operating Company, LLC to obtain complete medical records from each other provider being sent a notice.

Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell

Trammell Piazza Law Firm, PLLC

TN BPR No. 21146

418 N. State Line Avenue Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November 2015.

My commission expires: 3 - 38 - 33





418 N. State Line Ave. Texarkana, AR 71854 ph 870.779.1860 fx 870.779.1861 tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell chad@trammellpiazza.com

Melody H. Piazza Virginia C. Trammell

Of Counsel
Brian G. Brooks
Eric T. Bishop
Kimberly Norris
Deborah Riordan

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

RE:

Sarah Katherine Rodgers

Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

August 18, 2015

- (A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.
- B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.
- (C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.
- (D) A list of the name and address of all providers being sent this notice is attached to this notice.
- (E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv Enclosure

Provider List

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System Suite 2021 800 S Gay Street Knoxville, TN 37929

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346 SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Birth Date: Patient/Plan Member Name: 415-30-9090 5-15-26 SSC Lebanon Operating Company, LLC Provider's/Health Plan's Name: d/b/a Lebanon Health and Rehabilitation Center Address 1: Provider's/Health Plan's Address: Address 2: State: Zip: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed is this request for psychotherapy notes?

Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. Ato, then you may check as many items below as you need. Date(s) Date(s) Description: Description: Date(s): Description: Operative Information ∠ Labor/delivery sum. All PHI in medical record OB nursing assess Cath lab Admission form All Dates All Dates Postpartum flow sheet. Special test/therapy Dictation reports Of Service Of Service Rhytlun Strips N Physician orders X UB-92: Mursing Information of Intake/outtake Transfer forms Other: diagnostic films and studies X Clinical Test Medication Sheets Other: M ER Information I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, D I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🗈 Yes 🗆 No If yes, describe: Section C; Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Patent/Flan Member/Guardizn/Patient/Plan Member Representative: Date:

Revised 3/2003

-inola

alderell

Couldwell

Print Name of Patient/Plan Member's Representative:



Relationship to Patient/Plan Member:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: Sarah Katherine Rodgers 415-30-9090 5-15-26 SSC Lebanon Operating Company, LLC Provider's/Health Plan's Name d/b/a Lebanon Health and Rehabilitation Center Address 1: Provider's/Health Plan's Address: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? 🗆 Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. *No, then you may check as many items below as you need. Date(s) Description: Description: Date(s) Date(s): Description: a Labor/delivery sum. a Operative Information El All PHI in medical record OB nursing assess □ Cath lab rı Admission form □ Postpartum flow sheet. 11 Special test/therapy Dictation reports □ Itamized bill: Li Rhythm Strips m Physician orders □ UB-92: u Nursing Information u Intake/outtake ☐ Other: diagnostic films | and studies ☐ Transfer forms Clinical Test Other: □ ER Information ☐ Medication Sheets I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, II I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🗆 Yes 🗆 No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Passent/Flan Member/Guardizh/Patient/Plan Member Representative: Print Name of Patient/Plan Member's Representative: Relationship to Patient/Plan Member: inda Coldwell

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: Katherine Rodgers 5-15-26 415-30-9090 SSC Lebanon Operating Company, LLC Provider's/Health Plan's Name d/b/a Lebanon Health and Rehabilitation Center Address 1: Provider's/Health Plan's Address: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: Date: 7/11/6 COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? Yexes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

No, then you may check as many items below as you need. Date(s) Description: Date(s) Description: Date(s): Description: □ Labor/delivery sum. Operative Information n All PHI in medical record OB nursing assess □ Cath lab rı Admission form D Postpartum flow sheet n Special test/therapy Dictation reports n Itemized bill: u Rhytim Strips rı Physician orders o UB-92: □ Nursing Information n Intake/outtake □ Other: diagnostic films | and studies □ Transfer forms a Clinical Test Other: BR Information ☐ Medication Sheets I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, to Lunderstand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. Lunderstand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🗉 Yes 🗖 No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Date: Signature of Purenty lan Member/Guardian/Patient/Plan Member Representative: develo Relationship to Patient/Plan Member: Print Name of Patient/Plan Member's Representative: inda Caldwell

| UNITED STATES POSTAL SERVICE • |
|--------------------------------|
| |

Certificate Of Mailing

This Certificate of Making provides evidence that mail has been presented to USPS® for making This form may be used for domestic and international may

Trammell Piazza Law Firm, PLLC 418 North State Line Ave. Texarkana, AR 71854

To: SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Ce 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

PS Form **3817**, April 2007 PSN 7530-02-000-9065

| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
|--|-----------------------------------|
| Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 1. Article Addressed to: SSC Lebanon Operating Company, LL d/b/a Lebanon Health and Rehabilitation 1 Ravinia Drive Suite 1500 Atlanta, GA 30346 | |
| 2. Article Number (Transfer from service label) 7011 35 | 00 0002 7817 1953 |
| PS Form 3811, July 2013 Domestic F | Return Receipt |

AFFIDAVIT OF PERSON MAILING NOTICE

| |) |
|------------------|---|
| COUNTY OF MILLER |) |

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

- 1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.
- 2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center, c/o C T Corporation System, Suite 2021, 800 Gay Street Knoxville, TN 37929, as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letter.

Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

Exhibit 3, which is a HIPAA compliant medical authorization permitting SSC Lebanon Operating Company, LLC to obtain complete medical records from each other provider being sent a notice.

Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell

Trammell Piazza Law Firm, PLLC

TN BPR No. 21146

418 N. State Line Avenue Texarkana, AR 71854 Subscribed and sworn to before me this 24th day of November, 2015.

My commission expires: 3-38-3

KELLEY VASQUEZ MY COMMISSION # 12386943 EXPIRES: March 28, 2022 Miller County



418 N. State Line Ave. Texarkana, AR 71854 ph 870.779.1860 fx 870.779.1861 tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell chad@trammellpiazza.com

Melody H. Piazza Virginia C. Trammell

Of Counsel Brian G. Brooks Eric T. Bishop Kimberly Norris Deborah Riordan

August 18, 2015

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System Suite 2021 800 S Gay Street Knoxville, TN 37929

RE:

Sarah Katherine Rodgers

Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

- (A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.
- B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.
- (C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.
- (D) A list of the name and address of all providers being sent this notice is attached to this notice.
- (E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv Enclosure

Provider List

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346



SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: 415-30-9090 5-15-26 Sarah Katherine SSC Lebanon Operating Company, LLC Recipient's Name: Provider's/Health Plan's Name: d/b/a Lebanon Health and Rehabilitation Center Address 1: Provider's/Health Plan's Address: Address 2: State: Zip: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: Date: 7/11/6 Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121 Description of information to be used or disclosed Is this request for psychotherapy notes?

Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. Also, then you may check as many items below as you need. Description: Date(s) Date(s) Date(s): Description: Description: Operative Information ▼ Labor/delivery sum. All PHI in medical record M Cath lab M Special test/therapy y OB nursing assess MAdmission form All Dates All Dates p Postpartum flow sheet. Dictation reports Of Service Of Service N Physician orders M Rhythm Strips X UB-92: M Nursing Information M Intake/outtake Other: diagnostic films and studies Transfer forms Clinical Test Other: ER Information Medication Sheets acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, II

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.

2. My treatment, payment, enrollment or cligibility for benefits may not be conditioned on signing this authorization.

3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.

 If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? DYes DNo

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Parent/lan Megriber/Gugrdizh/Patient/Plan Member Representative:

Date: 7 21-15

Print Name of Patient/Play Member's Representative:

Relationship to Patient/Plan Member:

Linda Coldwell

Daughter

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: 415-30-9090 5-15-26 415-30-9090 ccipient's Name: SSC Lebanon Operating Company, LLC Recipient's Name: Provider's/Health Plan's Name: d/b/a Lebanon Health and Rehabilitation Center Address 1: Provider's/Health Plan's Address: Address 2: State: Zip: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? Tyes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. MNo, then you may check as many items below as you need. Date(s) Date(s) Description: Description: Date(s): Description: Labor/delivery sum. □ Operative Information ri All PHI in medical record □ OB nursing assess □ Cath lab ri Admission form D Postpartum flow sheet. ii Special test/therapy a Dictation reports □ Itemized bill: ti Rhytim Strips n Physician orders U Nursing Information D UB-92: u Intake/outtake Other: diagnostic films and studies □ Transfer forms Clinical Test □ Other: □ ER Information ☐ Medication Sheets l acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. I understand that: I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? of Yes of No. If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Propent/Plan Member/Guardian/Patient/Plan Member Representative: Print Name of Patient/Plan Member's Representative:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Birth Date: Patient/Plan Member Name: 415-30-9090 5-15-26 SSC Lebanon Operating Company, LLC Recipient's Name: Provider's/Health Plan's Name d/b/a Lebanon Health and Rehabilitation Center Address I: Provider's/Health Plan's Address: Address 2: State: Zin: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: Date: 7/11/6 COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. INo, then you may check as many items below as you need. Date(s) Date(s) Description: Description: Date(s): Description: a Labor/delivery sum. Operative Information a All PHI in medical record OB nursing assess Cath lab rı Admission form D Postpartum flow sheet. 11 Special test/therapy Dictation reports D Itemized bill: ti Rhythun Strips in Physician orders ப Nursing Information ⊔ UB-92: u Intake/outtake Other: diagnostic films and studies □ Transfer forms Clinical Test Other: □ ER Information m Medication Sheets I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? Tyes DNo If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Panenty lan Member/Guardian/Patient/Plan Member Representative: Relationship to Patient/Plan Member: Print Name of Patient/Plan Member's Representative: inda Caldwell

| The | POSTAL SERVICE o | Certificate Of Mailing | Tự me | |
|---------|---|--|----------|--|
| Fro | m: Trammell Plazz | mail has been presented to USPS for mailing a Law Firm, PLLC | | |
| | 418 North State Texarkana, AR | | | |
| To: | Suite 2021 | rating Company, LLC lth and Rehabilitation Co System | 9 | U.S. POSTAGE TEXARKANA, AR AUG 18, 15 AMOUNT 61.05 R2305E125034-07 |
| - PS | 800 S Gay Street Knoxville, TN 37929 | J00-9065 | | = 3 |

| COMPLETE THIS SECTION ON DELIV | /ERY |
|---|---|
| B. Received by Rrinted Name 5 D. Is delivery address different from item | ☐ Agent ☐ Addressee C. Date of Delivery |
| | ipt for Merchandls |
| Li Irisuleu iviali Li Collocton p | ☐ Yes |
| | A. Signature X |

| 7 ጔዓዛይ | For delivery informa |) MAIL™ RI nly; No Insuranc | e Coverage Provided) site at www.usps.com |
|-----------|--|---|--|
| 5187 5000 | Postage Certified Fee Return Receipt Fee (Endorsement Required) Restricted Delivery Fee | \$ \$3.45 \$2.80 \$0.00 \$0.00 \$0.00 | 0504 07 AUG-ohna2015 Here |
| 7011 3500 | d/b/a Leban | on Health and poration Syste Street | Company, LLC d Rehabilitation Cente em |

AFFIDAVIT OF PERSON MAILING NOTICE

| STATE OF ARKANSAS |) |
|-------------------|---|
| COUNTY OF MILLER |) |

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

- 1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.
- 2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006, as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letter.

Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

Exhibit 3, which is a HIPAA compliant medical authorization permitting SMV Lebanon, LLC c/o VCORP Services to obtain complete medical records from each other provider being sent a notice.

Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell

Trammell Piazza Law Firm, PLLC

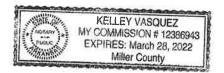
TN BPR No. 21146

418 N. State Line Avenue

Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

My commission expires: 3-28-22





418 N. State Line Ave. Texarkana, AR 71854 ph 870.779.1860 fx 870.779.1861 tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell chad@trammellpiazza.com

Melody H. Piazza Virginia C. Trammell

Of Counsel Brian G. Brooks Eric T. Bishop Kimberly Norris Deborah Riordan

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

RE:

Sarah Katherine Rodgers

Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

August 18, 2015

- (A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.
- B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.
- (C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.
- (D) A list of the name and address of all providers being sent this notice is attached to this notice.
- (E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv Enclosure

Provider List

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System Suite 2021 800 S Gay Street Knoxville, TN 37929

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346 SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

| AUTHORIZAT. | ION FOR RE | LEAS | E OF PROTEC | TED HEALT | HI | NFORMATION | (PHI) |
|---|--|--|---|---------------------------------------|---------|---|------------------|
| Section A: This section must | | | | | | | |
| | rine Rodg | jers | Birth Date: 5-15 | -26 | | Social Security No. 415 - 30-9 | |
| Provider's/Health Plun's Name | ð; | | Recipient's Name: | SMV L | ebar | non. LLC | |
| Provider's/Health Plan's Addr | ess: | | Address 1: | | Will J | MANAGE TO SERVICE THE SERVICE | |
| | | | Address 2: | IX | | | |
| | | | City: | | | State: | Zlp: |
| This authorization will expire a | | (Fill in t Event: | the Date or the Event | but not both.) | | | |
| | DMPLIANCE W | UTH T. | C.A. § 29-26-121 | | | | |
| | Des | cription | of information to be | used or disclose | ct | | |
| is this request for psychotherap another authorization for other | ry notes? □ Yes, items below. 🎾 | then thi No, then | s is the only item you you may check as m | i may request on any items below | this a | uthorization. You m u need. | ust submit |
| Description: | Date(s): | Descri | ption: | Date(s) | Des | cription: | Date(s) |
| MAII PHI in medical record Admission form Dictation reports Physician orders Intake/outtake Clinical Test Medication Sheets | All Dates Of Service | | | | | abor/delivery sum. B nursing assess estpartum flow sheet emized bill: B-92: ther: diagnostic films ther: | s and studies |
| l acknowledge, and hereby cons results or AIDS information. | ent to such, that t | the relea l) If no | sed information may t applicable, check h | contain alcohol, ere, tr | drug | abuse, psychiatric, Hf | V testing, HIV |
| I understand that: 1. I may refuse to sign this aut 2. My treatment, payment, one 3. I may revoke this authorizat revocation. Further details 4. If the requester or receiver i privacy regulations and may 5. I understand that I may see a 6. I get a copy of this form after | ollment or eligibil ion at any time in may be found in t s not a health plat be redisclosed, and obtain a copy | lity for to writing the Noti n or hea | penefits may not be or to but if I do, it will note toe of Privacy Practic alth care provider, the | ot have any effects. released inform | et on a | my actions taken prior | tected by federa |
| Section B: Is the request of PH fyes, the health plan or health c | I for the purpose are provider must | of mark t comple | eting? ete Section B, otherw | rise skip to Section | on C. | | |
| Will the recipient receive financi If yes, describe: | | | | | | nformation? n Yes | □ No |
| ection C: Signatures | | | | | | | |
| have read the above and authori | ze the disclosure | of the n | rotected health infor | nation as stated. | | | |
| ignature of Parent Plan Membe | | | | | Date: | 7-31-15 | |

Print Name of Patient/Plan Member's Representative:
Linola Coldwell
Revised 3/2003



Relationship to Patient/Plan Member:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

| Section A: This section must | be completed fo | r all Aut | horizations | | | AU | |
|--|---|---|---|--|-------------------------------|--|---|
| Patient/Plan Member Name: | . 0 . | | Birth Date: | | | Social Security No. | |
| Sarah Kather | ine Roda | dgers 5-15-26 415-30-9090 | | | 090 | | |
| Provider's/Health Plan's Name | | , | Recipient's Name: | | | | |
| Provider's/Health Plan's Addre | oss: | | Address 1: | | | | |
| | | | Address 2: | | | | |
| | | | City: | | | State: | Zip: |
| This authorization will expire of Date: 7/11/6 | on the following: | (Fill in t Event: | he Date or the Event | but not both.) | | | |
| Purpose of disclosure: CC | IMPLIANCE V | VLTH T. | C.A. § 29-26-121 | | | 455 | |
| | Des | scription | of information to be | used or disclose | d | | |
| Is this request for psychotherap another authorization for other | y notes? 🗆 Yes, items below. 🅦 | , then this No, then | s is the only item you you may check as m | may request on any items below | this at as you | uthorization. You mu u need. | st submit |
| Description: | Date(s): | Descri | ption: | Date(s) | Desc | cription; | Date(s) |
| cr All PHI in medical record cr Admission form cr Dictation reports cr Physician orders cr Intake/outtake cr Clinical Test cr Medication Sheets | | □ Cath □ Spec □ Rhyt □ Nurs □ Trans | ative Information lab ial test/therapy itm Strips ing Information sfer forms nformation | | o Ol o Po o Ita o Ul | abor/delivery sum. B nursing assess setpartum flow sheet emized bill: B-92: ther: diagnostic films ther: | and studies |
| acknowledge, and hereby consessits or AIDS information. | ent to such, that (Initia | the relea d) If no | sed information may t applicable, check h | contain alcohol ere, 13 | , drug s | abuse, psychiatric, HIV | testing, HIV |
| understand that: 1. I may refuse to sign this auth 2. My treatment, payment, enro 3. I may revoke this authorizati revocation. Further details 4. If the requester or receiver is privacy regulations and may 5. I understand that I may see a 6. I get a copy of this form after | ollment or eligibi ion at any time in may be found in s not a health pla be redisclosed, and obtain a copy | ility for b n writing the Noti an or hea | enefits may not be or , but if I do, it will n ce of Privacy Practic Ith care provider, the | ot have any effe es. released inforn | ect on a | ny actions taken prior may no longer be prot | ected by federa |
| Section B: Is the request of PH fyes, the health plan or health c | I for the purpose are provider mus | of marke | eting? ete Section B, otherw | rise skip to Secti | on C. | A. JAHA | -100 |
| Vill the recipient receive financi If yes, describe: | al or in-kind con | npensatio | on in exchange for us | ing or disclosing | g this i | nformation? n Yes c | 3 No |
| ection C: Signatures | 11 77 1 1 1 1 1 1 | | | | - | | |
| have read the above and authori | ze the disclosure | of the p | rotected health infor | mation as stated. | | | - 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 |
| ignature of Parenty lan Membe | r/Guardizh/Patic | nt/Plan N | Member Representati | ve: | Date: | 7-31-15 | v. Sealery Comment |
| int Name of Patient/Plus Memb | oer's Representat well | ive: | | | Refati | onship to Patient/Plan | Member: |

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: 5-15-26 415-30-9090 Sarah Katherine Rodgers Provider's/Health Plan's Name Address 1: Provider's/Health Plan's Address: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121 Description of information to be used or disclosed Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. DNo, then you may check as many items below as you need. Date(s) Description: Date(s) Date(s): Description: Description: Labor/delivery sum. □ Operative Information ri All PHI in medical record OB nursing assess □ Cath lab rı Admission form 11 Special test/therapy D Postpartum flow sheet. Dictation reports u Rhytinn Strips n Itamized bill: ra Physician orders ы UB-92: u Nursing Information u lutake/outtake □ Transfer forms ☐ Other: diagnostic films and studies Clinical Test Other: □ ER Information ☐ Medication Sheets I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, in I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? Tyes DNo If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated,

Revised 3/2003

Relationship to Patient/Plan Member:

Signature of Pastent Plan Member/Guardizh/Patient/Plan Member Representative:

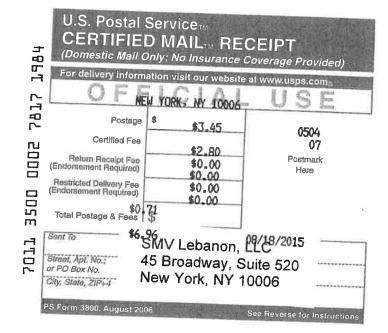
Print Name of Patient/Plan Member's Representative:

| VICE a | Certificate (| Of Mailin |
|--|---|-----------|
| mestic and infernational in the Plazza | Law Firm, | PLLC |
| kana, AR 7 | 1854 | |
| Broadway. | Suite 520 | |
| | ordes endence that must be mestic and universal must be mestic and universal order to the must be mestic and universal or the State I kana, AR 7. | |



PS Form 3817, April 2007 PSN 7530-02-000-9065





AFFIDAVIT OF PERSON MAILING NOTICE

| COUNTY OF MILLER | STATE OF ARKANSAS |) |
|------------------|-------------------|---|
| | COUNTY OF MILLER |) |

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

- 1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.
- 2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SMV Lebanon, LLC c/o VCORP Services, LLC, 15439 Old Hickory Blvd Nashville, TN 37211, as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letter.

Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

Exhibit 3, which is a HIPAA compliant medical authorization permitting SMV Lebanon, to obtain complete medical records from each other provider being sent a notice.

Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell

Trammell Piazza Law Firm, PLLC

TN BPR No. 21146

418 N. State Line Avenue Texarkana, AR 71854 Subscribed and sworn to before me this 24th day of November, 2015.

My commission expires: 3-28-22





418 N. State Line Ave. Texarkana, AR 71854 ph 870.779.1860 fx 870.779.1861 tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell chad@trammellpiazza.com

Melody H. Piazza Virginia C. Trammell

Of Counsel Brian G. Brooks Eric T. Bishop Kimberly Norris Deborah Riordan

August 18, 2015

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

RE:

Sarah Katherine Rodgers

Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

- (A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.
- B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.
- (C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.
- (D) A list of the name and address of all providers being sent this notice is attached to this notice.
- (E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv Enclosure

Provider List

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System Suite 2021 800 S Gay Street Knoxville, TN 37929

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346 SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

| AUTHORIZAT | ION FOR RE | CLEAS | E OF PROTEC | TED HEALT | HIN | FORMATION (| PHII) | |
|---|--|---|---|---|---|--|-----------------|--|
| Section A: This section must | be completed to | r all Aut | horizations | | | | 7 | |
| Patient/Plan Member Name: | | | Birth Date: | | | Social Security No. (optional): | | |
| Saran Katherine Rodgers | | | 5-15-26 415-30-9090 | | | | | |
| Provider's/Health Plan's Name: | | | Recipient's Name: SMV Lebanon, LLC | | | | | |
| Provider's/Health Plan's Address: | | | Address 1: | | | | | |
| | | | Address 2: | | | | | |
| | | | City: | | | State: | Zip: | |
| This authorization will expire to Date: 7/1/6 | | (Fill in t Event: | he Date or the Event | but not both.) | | | | |
| | OMPLIANCE W | ATH T. | C.A. § 29-26-121 | w.e.= | | | | |
| | Des | cription | of information to be | used or disclosed | d | | | |
| is this request for psychotherap another authorization for other | y notes? □ Yes, iterus below. 🎉 | then this No, then | s is the only item you you may check as m | may request on any items below | this aut | horization. You mu | st submit | |
| Description: | Date(s): | Descrip | otion: | n; Date(s) De | | iption: | Date(s) | |
| All PHI in medical record Admission form Dictation reports Physician orders Imake/outtake Clinical Test Medication Sheets | All Dates Of Service | M Operative Information M Cath lab M Special test/therapy M Rhythm Strips M Nursing Information M Transfer forms M ER Information | | All Dates Of Service | M Labor/delivery sum. M OB nursing assess M Postpartum flow sheet M Itemized bill: M UB-92: M Other: diagnostic films of Other: | | and studies | |
| acknowledge, and hereby consecults or AIDS information. | | he releas | | | drug ab | use, psychiatric, HIV | testing, HIV | |
| understand that; I may refuse to sign this authorized the My treatment, payment, enror I may revoke this authorization revocation. Further details of the requester or receiver is privacy regulations and may I understand that I may see at I get a copy of this form after | ollment or eligibil on al any time in may be found in t s not a health pla be redisclosed, nd obtain a copy | ity for be writing, the Notic t or head | enefits may not be co but if I do, it will no se of Privacy Practice th care provider, the | ot have any effectes. released information | t on any ation ma | actions taken prior of actions are actions taken protessing and longer he protessing | cted by federal | |
| ection B: Is the request of PHI yes, the health plan or health ca | | | | ise skip to Section | n C. | | | |
| ill the recipient receive financis If yes, describe: | al or in-kind com | pensation | n in exchange for usi | ng or disclosing | th i s info | ormation? ຕ Yes 🛚 | No | |
| ction C: Signatures | *** | | | | | | | |
| ave read the above and authoriz | e the disclosure | of the pr | otected health inform | nation as stated. | | Lagra | | |
| mature of Present lan Member | ember Representat/v | re: | Date: 7-31-15 | | | | | |
| ni Name of Patient/Plan Member's Representative: | | | | | Relationship to Patient/Plan Member: | | | |

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Patient/Plan Member Name: Social Security No. (optional): 415-30-9090 5-15-26 Provider's/Health Plan's Name: Recipient's Name: SMV Lebanon, LLC Provider's/Health Plan's Address: Address 1: Address 2: City: State: Zin: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121 Description of information to be used or disclosed another authorization for other items below. Yellow, then you may check as many items below as you need. Description: Date(s): Description: Date(s) Description: Date(s) ci All PHI in medical record a Operative Information Labor/delivery sum. Et Admission form □ Cath lab OB nursing assess Dictation reports in Special test/therapy D Postpartum flow sheet D Physician orders ti Rhytlun Strips □ Itemized bill: □ Intake/outtake □ Nursing Information ti UB-92: Clinical Test □ Transfer forms Other: diagnostic films and studies u Medication Sheets □ ER Information Other: l acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, in I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? of Yes of No. If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Parent Han Member/Guardian/Patient/Plan Member Representative: Date: Print Name of Patient/Plan Member's Representative: Relationship to Patient/Plan Member:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: Sarah Katherine Rodgers 415-30-9090 5-15-26 SMV Lebanon, LLC Address I: Provider's/Health Plan's Address: Address 2: State: Zip: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121 Description of information to be used or disclosed Is this request for psychotherapy notes? Myes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

No, then you may check as many items below as you need. Description: Date(s) Date(s) Description: Date(s): Description: n Labor/delivery sum. a Operative Information ri All PHI in medical record OB nursing assess □ Cath lab rı Admission form 11 Special test/therapy D Postpartum flow sheet. n Dictation reports □ Itamized bill: ta Rhythm Strips n Physician orders o UB-92: ☐ Nursing Information u Intake/outtake Other: diagnostic films and studies □ Transfer forms c Clinical Test ப Medication Sheets □ ER Information Other: I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, C I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🗆 Yes 🗆 No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated.

Revised 3/2003

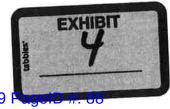
Signature of Passent/Plan Member/Guardian/Patient/Plan Member Representative:

Print Name of Patient/Plan Member's Representative:

Date:

Relationship to Patient/Plan Member:

| is form m | Certificate Of Mail at a of Mailing provides evidence that mail has been presented to USES® for mail to be used for domestic and international mail. | ing |
|-----------|--|------------|
| om: | Trammell Piazza Law Firm, PLI | 1 |
| | 418 North State Line Ave. | <i>.</i>) |
| | Texarkana, AR 71854 | ₽ € |
| | | Εξ. ω |



| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
|---|---|
| Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. Article Addressed to: | A. Signature X. Angent Addressee B. Received by (Printed Name) SHAUN STALLINGS D. Is delivery address different from item 1? Yes If YES, enter delivery address below: |
| c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211 | 3. Service Type Certified Mail Registered Insured Mail Collect on Delivery |
| | 4. Restricted Delivery? (Extra Fee) |
| (Transfer from service label) | 500 0002 7817 1977 |
| PS Form 3811, July 2013 Domestic | Return Receipt |

| 7257 | U.S. Postal Service To CERTIFIED MAIL TO RECEIPT (Domestic Mail Only; No Insurance Coverage Provide For delivery information visit our website at www.usps.com | |
|------|--|----------------------|
| 617 | OF NASHUILE, THATELE S. | user Imag Imag |
| 78. | Postage \$ \$3.45 0564 | 11 |
| 000 | Certified Fee Return Receipt Fee (Endorsement Required) \$2.80 \$0.00 Here | Jan . |
| 500 | Restricted Delivery Fee (Endorsement Required) \$0.00 \$0.00 | 2 |
| ריז | Total Postar Sent To SMV Lebanon, LLC | |
| 7011 | c/o VCORP Services, LLC or PO Box No. 15439 Old Hickory Blvd City, State, ZiF Nashville, TN 37211 | ********** |
| | PS Form 3800. August 2006 See Reverse for Ir | structions |

AFFIDAVIT OF PERSON MAILING NOTICE

| STATE OF ARKANSAS |) |
|-------------------|---|
| COUNTY OF MILLER |) |

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

- 1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.
- 2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA 30060, as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letter.

Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

Exhibit 3, which is a HIPAA compliant medical authorization permitting SavaSeniorCare, LLC c/o The Corporation Company to obtain complete medical records from each other provider being sent a notice.

Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell

Trammell Piazza Law Firm, PLLC

TN BPR No. 21146

418 N. State Line Avenue Texarkana. AR 71854 Subscribed and sworn to before me this 24th day of Wovembur, 2015.

| Letter Varquer | NOTARY PUBLIC

My commission expires: 3-38.22



418 N. State Line Ave. Texarkana, AR 71854 ph 870.779.1860 fx 870.779.1861 tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell chad@trammellpiazza.com

Melody H. Piazza Virginia C. Trammell

Of Counsel Brian G. Brooks Eric T. Bishop Kimberly Norris Deborah Riordan

August 18, 2015

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

RE:

Sarah Katherine Rodgers

Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

- (A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.
- B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.
- (C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.
- (D) A list of the name and address of all providers being sent this notice is attached to this notice.
- (E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv Enclosure



Provider List

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System Suite 2021 800 S Gay Street Knoxville, TN 37929

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

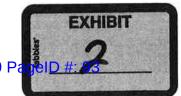
SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346



SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

| AUTHORIZATI | ON FOR RE | LEAS | E OF PROTECT | ED HEALT | H INFORMATION | PHI) | | |
|--|--|---|---|----------------------------|---|--------------------|--|--|
| Section A: This section must I | | - | | | | | | |
| Patient/Plan Member Name: | | Birth Date: | | | | | | |
| Sarah Katherine Rodgers | | | 5-15 | 5-15-26 415-30-9090 | | | | |
| Provider's/Health Plan's Name: | | | Recipient's Name: | | eniorCare, LLC | | | |
| Provider's/Health Plan's Address: | | | Address 1: | | In the | | | |
| | | | Address 2: | | | and the second | | |
| | | | City: | | State: | Zlp: | | |
| This authorization will expire of Date: 7/1/6 | n the following: (| Fill in (Event: | the Date or the Event | but not both.) | | 1.000 | | |
| Purpose of disclosure: CC | IMPLIANCE W | TH T. | C.A. § 29-26-121 | | | | | |
| J. 110-117 | Des | cription | of information to be | used or disclosed | | | | |
| Is this request for psychotherap another authorization for other | y notes? Yes, items below. | then the | is is the only item you a you may check as m | may request on a | this authorization. You make you need. | ust submit | | |
| Description: | Date(s): | Descri | | Date(s) | Description: | Date(s) | | |
| MAII PHI in medical record MAdmission form Dictation reports Physician orders Intake/outtake Clinical Test Medication Sheets | All Dates Of Service | Lif Canadal toet/therany | | All Dates Of Service | V Postpartum flow sneet Itemized bill: VUB-92: Other: diagnostic films and stud | | | |
| I acknowledge, and hereby convesults or AIDS information. | sent to such, that | the refe l) If n | ased information may of applicable, check h | contain alcohol, ere. 🗆 | drug abuse, psychiatric, Fil | V testing, HIV | | |
| I understand that: 1. I may refuse to sign this aut 2. My treatment, payment, em 3. I may revoke this authorizat revocation. Further details 4. If the requester or receiver i privacy regulations and may 5. I understand that I may see a 6. I get a copy of this form after | ollment or eligibition at any time it may be found in s not a health plate be redisplosed, and obtain a copy or f sign it. | lity for a writin the Nor an or he of the | benefits may not be eg, but if I do, it will n tice of Privacy Practic alth care provider, the information described | es. e released inform | nation may no longer be pro | ntected by federal | | |
| Section B: Is the request of PH If yes, the health plan or health | If for the purpose care provider mus | of mar t comp | keting? lete Section B, otherw | vise skip to Section | on C. | | | |
| Will the recipient receive financ | ial or in-kind con | າເວຍກາຣຄາ | ion in exchange for us | sing or disclosing | this information? TYes | □ No | | |
| If yes, describe: | | | | | | | | |
| Section C: Signatures | | | | | | | | |
| I have read the above and author | ize the disclosure | of the | protected health infor | mation as stated. | | | | |
| Signature of Parentiflan Member | er/Guardizh/Palie | nt/Plan | Member Representat | ive: | Date: 7-31-15 | | | |
| Print Name of Patient/Plan Mem | per's Representat | ive: | 10000 1100 1100 1100 1100 1100 1100 11 | | Relationship to Patient/Pla | | | |
| Levised 3/2003 | | | | | ~ | | | |

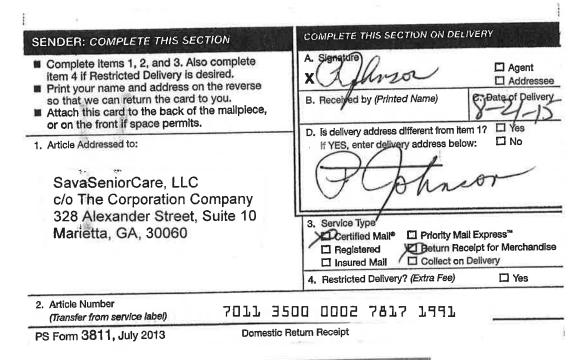
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Birth Date: Patient/Plan Member Name: 415-30-9090 5-15-26 Katherine Recipient's Name: Provider's/Health Plan's Name: SavaSeniorCare, LLC Provider's/Health Plan's Address: Address I: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: Date: 7/11/6 COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? \square Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need. Description: Date(s) Date(s) Description: Date(s): Description: Labor/delivery sum. ☐ Operative Information a All PHI in medical record n OB nursing assess □ Cath lab ra Admission form D Postpartum flow sheet. ii Special test/therapy Li Dictation reports □ Itemized bill: a Rhythm Strips n Physician orders u UB-92: @ Nursing Information m Intake/outtake Other: diagnostic films and studies ☐ Transfer forms Clinical Test □ Other: □ BR Information ☐ Medication Sheets I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, to I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🗆 Yes 🗆 No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Passent/Plan Member/Guardizh/Patient/Plan Member Representative: Relationship to Patient/Plan Member: Print Name of Patient/Plan Member's Regresentative: Caldwell Linda

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

| Section A: This section must l | e completed for a | II Aut | horizations | | | | i i i i i i i i i i i i i i i i i i i |
|---|--|---------------------------------------|--|-----------------------------------|---|------------------------|---------------------------------------|
| Patient/Plan Member Name: | | | Birth Date: | | Social Security No. (optional) | | optional): |
| Sarah Katherine Rodgers | | | 5-15 | -26 | 415-30-9090 | | 090 |
| Provider's/Health Plun's Name: | | | Recipient's Name: SavaSeniorCare, LLC | | | | |
| Provider's/Health Plan's Addre | ess: | | Address I: | | | | |
| | | | Address 2: | | | | |
| | | | City: | | State: | 7 | lip: |
| This authorization will expire u | n the following: (F | ill in t | the Date or the Event | but not both.) | | | |
| | MPLIANCE WE | TH T. | C.A. § 29-26-121 | | | | |
| | Descr | ription | of information to be | used or disclose | d | | |
| is this request for psychotherap another authorization for other | y notes? XYes, th | hen the | is is the only item you you may check as m | muy request on any items below | this authorization. Yas you need. | ou nus | t submit |
| Description: | | | iption: | Date(s) | Description: | | Date(s) |
| n All PHI in medical record n Admission form u Dictation reports n Physician orders u Intake/outtake □ Clinical Test u Medication Sheets | | □ Catl □ Spe □ Rhy □ Nur □ Trar □ ER | cial tesUtherapy tlun Strips sing Information isfer forms Information | | □ Labor/delivery su □ OB nursing asses □ Postpartum flow su □ Itemized bill: □ UB-92: □ Other: diagnosti □ Other: | s sheet ic films | and studies |
| I acknowledge, and hereby con- results or AIDS information. | sent to such, that th (Initial) | ne rele | ased information may ot applicable, check h | contain alcohol ere, 🗆 | , drug abuse, psychiau | rie, HIV | testing, HIV |
| I understand that: 1. I may refuse to sign this aut 2. My treatment, payment, enr 3. I may revoke this authorizat revocation. Further details 4. If the requester or receiver privacy regulations and may 5. I understand that I may see 6. I get a copy of this form after | ollment or eligibili tion at any time in a may be found in this is not a health plan be redisclosed, and obtain a copy of | ity for writin he No i or he | benefits may not be on g, but if I do, it will re- tice of Privacy Practic malth care provider, the | ces. e released infor | nation may no longer | be prote | ected by federal |
| C. C. D. Justin suggest of Ph | If for the numose o | of mar | keting? | wise skin to Sect | ion C. | | |
| If yes, the health plan or health Will the recipient receive finance | care provider must | comp | ion in eychange for u | sing or disclosin | g this information? | 1 Yes τ |] No |
| If yes, describe: | agi oi m-killo com | herraer | Ku u avorrando vo. | g | | | |
| Section C: Signatures | | | -N2 ((i/n/ | | | | maps of |
| I have read the above and author | rice the disclosure | of the | protected health info | rmation as stated | i, | | |
| Signature of Parent Plan Memb | | | | | Date: 7-31- | -15 | |
| Print Name of Patient/Plan Mem | per's Representati | ve: | | | Relationship to Patie | nt/Plan | Member: |

| Certificate Of Mailing |
|---|
| mail has been presented to USPS® for mailing or of mail |
| a Law Firm, PLL(|
| e Line Ave. |
| 71854 |
| LLC ion Company treet, Suite 10 |
| |









AFFIDAVIT OF PERSON MAILING NOTICE

| STATE OF ARKANSAS |) |
|-------------------|---|
| |) |
| COUNTY OF MILLER |) |

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

- 1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.
- 2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346, as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letter.

Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

Exhibit 3, which is a HIPAA compliant medical authorization permitting Tennessee HoldCo, LLC to obtain complete medical records from each other provider being sent a notice.

Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell

Trammell Piazza Law Firm, PLLC

TN BPR No. 21146

418 N. State Line Avenue

Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

| Letter Varguery | NOTARY PUBLIC

My commission expires: 3-28-22

KELLEY VASQUEZ MY COMMISSION # 12386943 EXPIRES: March 28, 2022 Miller County



418 N. State Line Ave. Texarkana, AR 71854 ph 870.779.1860 fx 870.779.1861 tf 888,989,1860

Melody H. Piazza

M. Chad Trammell

chad@trammellpiazza.com

Virginia C. Trammell

Of Counsel Brian G. Brooks

Eric T. Bishop

Kimberly Norris Deborah Riordan

TrammellPiazza.com

August 18, 2015

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

RE:

Sarah Katherine Rodgers

Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

- (A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.
- B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.
- (C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.
- (D) A list of the name and address of all providers being sent this notice is attached to this notice.
- (E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv Enclosure

Provider List

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System Suite 2021 800 S Gay Street Knoxville, TN 37929

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

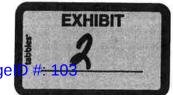
SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346



SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

| AUTHORIZATI | ON FOR RE | LEAS | E OF PROTECT | TED HEALT | H INFORMATION | PHI) | |
|--|---|---|--|--|---|--------------------|--|
| Section A: This section must | | | | | | | |
| Patient/Plan Member Name: | | | Birth Date: | | Social Security No. | | |
| Sarah Katherine Rodgers | | | 5-15-26 415-30-9090 | | | | |
| Provider's/Health Plan's Name: | | | Recipient's Name: | Tennesse | ee HoldCo, LLC | | |
| Provider's/Health Plan's Addra | oss: | | Address 1: | 11-16- | | | |
| | | | Address 2: | | | | |
| | | | City: | 400 m = 1 | State: | Zip: | |
| This authorization will expire of Date: 7/1/6 | on the following: (| (Fill in I Event: | the Date or the Event | but not both.) | | | |
| | OMPLIANCE W | ITH T. | C.A. § 29-26-121 | | | | |
| | Desc | cription | of information to be | used or disclosed | | | |
| Is this request for psychotherap another authorization for other | y notes? - Yes, | then thi | is is the only item you you may check as m | may request on any items below | this authorization. You make you need. | ust submit | |
| Description: | Date(s): | Descri | 7 | Date(s) | Description: | Date(s) | |
| M All PHI in medical record of Admission form The Dictation reports A Physician orders Intake/outtake Clinical Test Medication Sheets | All Dates Of Service | ✓ Operative Information ✓ Cath lab ✓ Special test/therapy ✓ Rhythm Strips ✓ Nursing Information ✓ Transfer forms ✓ ER Information | | All Dates Of Service | Labor/delivery sum. OB nursing assess Postpartum flow sheet. Itemized bill: UB-92: Other: diagnostic films and stu | | |
| I acknowledge, and hereby con- results or AIDS information. | sent to such, that t | he relea | ased information may a applicable, check h | contain alcohol, ere, 🗆 | drug abuse, psychiatric, Hl | V testing, HIV | |
| I understand that: I. I may refuse to sign this aut My treatment, payment, enr J. I may revoke this authorizat revocation. Purther details If the requester or receiver i privacy regulations and may J. I understand that I may see t L. I get a copy of this form after | ollment or eligibil ion al any time in may be found in is not a health pla be redisclosed. and obtain a copy | lity for writing the Not n or he | benefits may not be come, but if I do, it will no ice of Privacy Practiculation the care provider, the | or have any effectes. e released inform | ation may no longer be pro | ntected by federal | |
| Section B: Is the request of PH If yes, the health plan or health of | If for the purpose care provider mus | of mark | teting? lete Section B, otherw | rise skip to Section | on C. | | |
| Will the recipient receive financ | | | | | | □ No | |
| If yes, describe: | | | | | CALL TO THE PARTY OF THE PARTY | | |
| Section C: Signatures | | | | | | | |
| have read the above and author | ize the disclosure | of the p | protected health infor | mation as stated. | | | |
| Signature of Purenty lan Member | | nt/Plan | Member Representat: | | Date: 7-31-15 | | |
| rint Name of Patient/Plan Mem | | ive: | | | Relationship to Patient/Plan | n Member: | |
| Levised 3/2003 | | | - Control of the Cont | | The second second | | |

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: 415-30-9090 Sarah Katherine Kodgers Recipient's Name: Provider's/Health Plan's Name: Tennessee HoldCo. LLC Address 1: Provider's/Health Plan's Address: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the fivent but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes?

Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need. Date(s) Date(s) Description: Description: Date(s): Description: Labor/delivery sum. □ Operative Information ri All PHI in medical record OB nursing assess □ Cath lab ri Admission form □ Postpartum flow sheet 11 Special test/therapy Dictation reports n Itemized bill: ta Rhytlun Strips n Physician orders D UB-92: u Nursing Information u Intake/outtake Other: diagnostic films and studies □ Transfer forms Clinical Test □ ER Information Other: □ Medication Sheets I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, IT I understand that: I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer he protected by federal privacy regulations and may be redisclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? TYes a No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Parent/Flan Member/Guardizh/Patient/Plan Member Representative: Onte: Relationship to Patient/Plan Member: Print Name of Patient/Plan Member's Representative: Caldwel -inota

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: 5-15-26 415-30-9090 Katherine Rodgers Recipient's Name: Tennessee HoldCo, LLC Address 1; Provider's/Health Plan's Address: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

□ No, then you may check as many items below as you need. Description: Date(s) Date(s) Description: Date(s): Description: a Operative Information Labor/delivery sum. ri All PHI in medical record OB nursing assess □ Cath lab rı Admission form 11 Special test/therapy n Postpartum flow sheet ta Dictation reports ☐ Itamized bill: LI Rhythm Strips n Physician orders u UB-92: D Nursing Information c) Intake/outtake ☐ Transfer forms □ Other: diagnostic films | and studies a Clinical Test D Other: ☐ ER Information u Medication Sheets l acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🗆 Yes 🗆 No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Pastentfflan Member/Guardizh/Patient/Plan Member Representative: Date:

Revised 3/2003

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

| UNITED STATES POSTAL SERVICE • | Certificate Of Mail |
|---|--|
| This Certificate of Making provides evidence that this form may be used for domestic and internation: Trammell Plazz | mail has been presented to USPS for mail a Law Firm PIIC |
| 418 North State | Line Ave. |
| Texarkana, AR | 71854 |
| Tennessee HoldCo One Ravinia Drive, Atlanta, GA 30346 | o, LLC —— Suite 1500 —— |
| PS Form 3817 . April 2007 PSN 7530- | -02-000-9065 |



M HE

| SENDER: COMPLETE THIS S | ECTION | | COMPLETE THIS SECTI | ON ON DELIV | 'ERY |
|---|--|-------------|---|-----------------|--------------------|
| Complete items 1, 2, and 3. / item 4 if Restricted Delivery is Print your name and address so that we can return the car Attach this card to the back or on the front if space permit 1. Article Addressed to: Tennessee HoldCo, Leading and the space of | s desired. on the reverse d to you. of the mailpled its. | • | A. Signature X B. Reseived by (Printed) D. Is delivery address diff If YES, enter delivery | erent from Item | |
| One Ravinia Drive, S Atlanta GA 30346 | uite 1500 | | ☐ Registered ➤ | Collect on De | pt for Merchandise |
| D. Add de Novelege | | | 4. Hostilotod Bolleoiy. p | | |
| Article Number (Transfer from service label) | 7011 | 3500 | 0002 7817 3 | 1922 | |
| PS Form 3811, July 2013 | Don | nestic Retu | ırn Receipt | | |

U.S. Postal Service CERTIFIED MAIL RECEIPT 1,922 (Domestic Mail Only; No Insurance Coverage Provided) 7817 Postage \$3.45 2000 Certified Fee \$2.80 \$0.00 \$0.00 \$0.00 \$0.00 Return Receipt Fee (Endorsement Required) Postmark NO 18 2015 Restricted Delivery Fee (Endorsement Required) 3500 Total Postage & Fees \$ Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Street, Apt. or PO Box Atlanta, GA 30346 City, State, PS Form 3800, August 2006 See Reverse for Instructions

AFFIDAVIT OF PERSON MAILING NOTICE

| STATE OF ARKANSAS |) |
|-------------------|---|
| COUNTY OF MILLER |) |
| COUNTY OF MILLER | , |

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

- 1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.
- 2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346, as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letter.

Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

Exhibit 3, which is a HIPAA compliant medical authorization permitting SSC Submaster Holdings, LLC to obtain complete medical records from each other provider being sent a notice.

Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell

Trammell Piazza Law Firm, PLLC

TN BPR No. 21146

418 N. State Line Avenue Texarkana, AR 71854 Subscribed and sworn to before me this 24th day of November, 2015.

My commission expires: 3-28-32





418 N. State Line Ave. Texarkana, AR 71854 ph 870.779.1860 fx 870.779.1861 tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell chad@trammellpiazza.com

Melody H. Piazza Virginia C. Trammell

Of Counsel Brian G. Brooks Eric T. Bishop Kimberly Norris Deborah Riordan

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

RE:

Sarah Katherine Rodgers

Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

August 18, 2015

- (A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.
- B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.
- (C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.
- (D) A list of the name and address of all providers being sent this notice is attached to this notice.
- (E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv Enclosure

Provider List

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System Suite 2021 800 S Gay Street Knoxville, TN 37929

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346 SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

| AUTHORIZATI | ON FOR RE | LEAS | E OF PROTECT | red healt | H I | FORMATION (| PHT) |
|--|---|---|---|--|--------|--|------------------|
| Section A: This section must I | | | | | | | |
| Patient/Plan Member Name: | | | Birth Date: 5-15-26 | | | Social Security No. (optional): 415 - 30-9090 | |
| Sarah Katherine Codgers Provider's/Health Plun's Name: | | | Recipient's Name: SSC Submaster Holdings, LLC | | | | |
| Provider's/Health Plan's Address: | | | Address 1: | | | | |
| | | | Address 2: | | | | |
| | | | City: | | | State: | Zip: |
| This authorization will expire a Date: 7/1/6 | on the following: (| Fill in t Event: | he Date or the Event | but not both.) | | | |
| Purpose of disclosure: CC | DMPLIANCE W | ITH T. | C.A. § 29-26-121 | | | | - A DOWN |
| 0 | Desc | cription | of information to be | used or disclose | d | | |
| is this request for psychotherap another authorization for other | y notes? - Yes, items below. | then thi | s is the only item you you may check as m | mny request on any items below | this a | uthorization. You nu u need. | ıst submit |
| Description: | Date(s): | Descri | ption: | Date(s) | Des | cription: | Date(s) |
| All PHI in medical record of Admission form of Dictation reports of Physician orders of Intake/outtake of Clinical Test Medication Sheets | All Dates Of Service | A Cath A Spec A Rhy A Nurs A Tran A ER I | cial test/therapy tum Strips sing Information sfer forms nformation | All Dates Of Service | Other: | | 1 |
| I acknowledge, and hereby con- results or AIDS information. | sent to such, that t | he relea | sed information may a applicable, check h | contain alcohol, ere, 17 | drug | abuse, psychiatric, HI | V testing, HIV |
| I understand that: I. I may refuse to sign this aut My treatment, payment, enr J. I may revoke this authorizat revocation. Further details Fithe requester or receiver i privacy regulations and may J. I understand that I may see t Light a copy of this form after | ollment or eligibilition at any time in may be found in is not a health pla be redisclosed, and obtain a copy | lity for writing the Not n or he | benefits may not be c | ot have any enects. e released inform | nation | may no longer be pro | tected by federa |
| Section B: Is the request of PH If yes, the health plan or health | If for the purpose care provider mus | of mark | eting? ete Section B, otherw | vise skip to Secti | on C. | | |
| Will the recipient receive financ | ial or in-kind com | pensati | on in exchange for us | sing or disclosin | g this | information? cr Yes | □ No |
| If yes, describe: | | | | | | | |
| Section C: Signatures | i na tha dinalamma | ofthe | protected health infor | mation as stated | | | |
| I have read the above and authorize the disclosure of the protected health information as stated. Signature of Particular Member/Guardian/Patient/Plan Member Representative: Date: 7-31-15 | | | | | • | | |

Print Name of Patient/Plan Member's Representative:
Linola Couldwell
Revised 3/2003

Relationship to Patient/Plan Member:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: 415-30-9090 5-15-26 Katherine Kodgers Sarah Recipient's Name: Provider's/Health Plun's Name SSC Submaster Holdings, LLC Provider's/Health Plan's Address: Address 1: Address 2: Zin: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: Date: 7/11/6 COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? - Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need. Date(s) Date(s) Description: Description: Description: Date(s): □ Operative Information Labor/delivery sum. El All PHI in medical record n OB nursing assess □ Cath lab ri Admission form D Postpartum flow sheet 11 Special test/therapy ra Dictation reports tı Rhytlım Strips □ Itemized bill: n Physician orders ⊔ UB-92: u Nursing Information m Intake/outtake U Other: diagnostic films and studies Transfer forms Clinical Test Other: □ ER Information ☐ Medication Sheets I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, to I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🗆 Yes 🗆 No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Purent Han Member/Guardizh/Patient/Plan Member Representative: Date: Relationship to Patient/Plan Member: Print Name of Patient/Plan Member's Regresentative: Caldwel -inola

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: 5-15-26 415-30-9090 Katherine Rodgers Recipient's Name: SSC Submaster Holdings, LLC Provider's/Health Plan's Name Provider's/Health Plan's Address: Address I: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. DNo, then you may check as many items below as you need. Date(s) Description: Date(s) Description: Date(s): Description: Labor/delivery sum. □ Operative Information ri All PHI in medical record n OB nursing assess □ Cath lab n Admission form D Postpartum flow sheet ii Special test/therapy til Dictation reports a Itemized bill: D Rhythm Strips n Physician orders ப UB-92: □ Nursing Information u Intake/outtake Other: diagnostic films and studies Transfer forms Clinical Test D Other: □ ER Information u Medication Sheets I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? of Yes of No. If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated Signature of Pagenty lan Member/Gugrdjan/Patient/Plan Member Representative: Date: alderelt Relationship to Patient/Plan Member: Print Name of Patient/Play Member's Representative: inda Caldwell



Certificate Of Mailii

This Certificate of Making provides evidence that mail has been presented to USPS® for mail this form may be used for domestic and internethenal mail

From: Trammell Piazza Law Firm, PLLC

418 North State Line Ave.

Texarkana, AR 71854

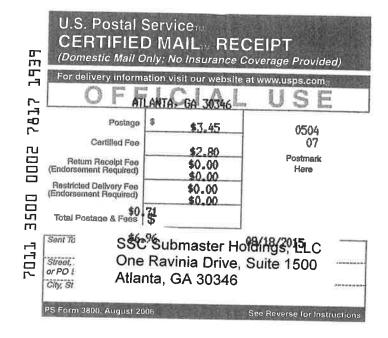
SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

PS Form 3817, April 2007 PSN 7530-02-000-9065





| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY | | | |
|---|---|--|--|--|
| Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse | A. Signature X Agent Addressee | | | |
| so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. | B. Received by (Printed Name) C. Date of Delivery | | | |
| 1. Article Addressed to: SSC Submaster Holdings, LLC | □ D. Is delivery address different from item 1? □ Yes If YES, enter delivery address below: □ No | | | |
| One Cavinia Drive, Suite 1500 | 3. Service Type Gertified Mail® □ Priority Mail Express™ □ Registered □ Insured Mail □ Collect on Delivery | | | |
| | 4. Restricted Delivery? (Extra Fee) ☐ Yes | | | |
| 2. Article Number (Transfer from service label) 7011 35 | 00 0002 7817 1939 | | | |
| PS Form 3811, July 2013 Domestic F | Return Receipt | | | |



AFFIDAVIT OF PERSON MAILING NOTICE

| STATE OF ARKANSAS |) |
|-------------------|---|
| OCUPITY OF MULED |) |
| COUNTY OF MILLER |) |

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

- 1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.
- 2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SavaSeniorCare Consulting, LLC c/o the Corpration Company 328 Alexander Street, Suite 10 Marietta, GA 30060, as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letter.

Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

Exhibit 3, which is a HIPAA compliant medical authorization permitting SavaSeniorCare Consulting, LLC c/o the Corpration Company to obtain complete medical records from each other provider being sent a notice.

Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell

Trammell Piazza Law Firm, PLLC

TN BPR No. 21146

418 N. State Line Avenue Texarkana, AR 71854 Subscribed and sworn to before me this 24th day of November, 2015.

| Uly Vaguery | NOTARY PUBLIC





418 N. State Line Ave. Texarkana, AR 71854 ph 870.779.1860 fx 870.779.1861 tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell chad@trammellpiazza.com

Melody H. Piazza Virginia C. Trammell

Of Counsel Brian G. Brooks Eric T. Bishop Kimberly Norris Deborah Riordan

August 18, 2015

SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

RE:

Sarah Katherine Rodgers

Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

- (A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.
- B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.
- (C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.
- (D) A list of the name and address of all providers being sent this notice is attached to this notice.
- (E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv Enclosure



Provider List

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System Suite 2021 800 S Gay Street Knoxville, TN 37929

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

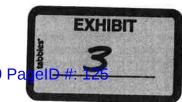
SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346 SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

| AUTHORIZATI | ION FOR RE | LEAS | E OF PROTECT | red healt | нг | NFORMATION (| (PHI) |
|---|--|--|---|--------------------------------|--|---------------------------------|-------------------|
| Section A: This section must I | | | | | | | |
| Patient/Plan Member Name: | | | Birth Date: | | | | |
| Sarah Katherine Rodgers | | | 5-15 | -26 | | 415-30-9 | 7090 |
| Provider's/Health Plan's Name | | | Recipient's Name: | SavaSei | nior(| Care Consulting | ı, LLC |
| Provider's/Health Plan's Addre | 0881 | | Address 1: | | | | |
| | | | Address 2: | | | | |
| | | | City: | | | State: | Zip: |
| This authorization will expire of Date: 7/1/6 | | (Fill in t Event: | the Date or the Event | but not both.) | | ilessioner maner | |
| | OMPLIANCE W | ITH T. | C.A. § 29-26-121 | IPM TO THE RESIDENCE | | | |
| | Des | cription | of information to be | used or disclosed |] | | |
| is this request for psychotherap another authorization for other | y notes? Yes, items below. | then thi | is is the only item you i you may check as m | may request on any items below | this at | uthorization. You nu u need. | ust submit |
| Description: | f)ale(s): | Descri | | Date(s) | 4 | scription: | Date(s) |
| All PHI in medical record of Admission form to Dictation reports to Physician orders of Intake/outlake to Clinical Test Medication Sheets | All Dates Of Service | (Operative Information (Cath lab (Special test/therapy (A Rhythm Strips (A Nursing Information (A Transfer forms (ER Information | | All Dates Of Service | Labor/delivery sum. Postpartum flow sheet. Itemized bill: UB-92: Other: diagnostic films and stu | | 1 |
| Lacknowledge, and hereby cons | sent to such, that t | he relea | ased information may or applicable, check hu | contain alcohol, ere. ti | drug | abuse, psychiatric, HI | V testing, HIV |
| I understand that: I may refuse to sign this audition. My treatment, payment, one I may revoke this authorizate revocation. Further details If the requester or receiver in privacy regulations and may I understand that I may see a I get a copy of this form after | ollment or cligibil tion at any time in may be found in t is not a health pla be redisclosed, and obtain a copy | lity for h writing the Noti m or hea | benefits may not be co g, but if I do, it will no lice of Privacy Practico alth care provider, the | e released inform | ct on a | may no longer he pro | tected by federal |
| Section B: Is the request of PH If yes, the health plan or health of | II for the numose | of mark | ceting? lete Section B, otherw | vise skip to Section | on C. | | |
| Will the recipient receive finance If yes, describe: | | | | | | information? n Yes | □ No |
| Section C: Signatures | | | 3)) - Jin | | | | |
| have read the above and author | ice the disclosure | of the | protected health infor | mation as stated. | | | VII.V. |
| Signature of Paident Han Membe | er/Gugrdizh/Patier | | | | Date: | 7-31-15 | |
| Malde | cer | | | | | | |

Print Name of Patient/Plan Member's Representative:
Linola Couldwell
Revised 3/2003



Relationship to Patient/Plan Member:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: 415-30-9090 Katherine Kodgers 5-15-26 Jarah Recipient's Name: Provider's/Health Plan's Name SavaSeniorCare Consulting, LLC Provider's/Health Plan's Address: Address 1: Address 2: State: Zin: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: Date: 7/11/6 COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? 🗆 Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. KNo, then you may check as many items below as you need. Description: Date(s) Description: Date(s) Date(s): Description: □ Operative Information Labor/delivery sum. ci All PHI in medical record OB nursing assess r Cath lab rt Admission form D Postpartum flow sheet □ Special test/therapy Li Dictation reports 🗆 Rhytlun Strips □ Itemized bill: m Physician orders ⊔ UB-92: U Nursing Information u Intake/outtake U Other: diagnostic films and studies □ Transfer forms Clinical Test Other: □ ER Information ☐ Medication Sheets I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV (Initial) If not applicable, check here, r results or AIDS information. I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🛛 Yes 🗆 No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Pupentillian Member/Guardizh/Patient/Plan Member Representative: Date:

Revised 3/2003

Linda

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member;

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Birth Date: Patient/Plan Member Name: 415-30-9090 Katherine Kodgers 5-15-26 Provider's/Health Plan's Name SavaSeniorCare Consulting, LLC Address 1: Provider's/Health Plan's Address: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

No, then you may check as many items below as you need. Date(s) Description: Date(s) Description: Date(s): Description: a Labor/delivery sum. □ Operative Information CI All PHI in medical record n OB nursing assess □ Cath lab rı Admission form n Postpartum flow sheet LI Special test/therapy Dictation reports D Itemized bill: 12 Rhythm Strips ra Physician orders □ UB-92: u Nursing Information u Intake/outtake Other: diagnostic films and studies Trænsfer forms Clinical Test Other: □ ER Information ☐ Medication Sheets 1 acknowledge, and hereby consent to such, that the released information may centain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, a Lunderstand that: I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? of Yes of No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Paulent/Flan Member/Guardizn/Patient/Plan Member Representative: Date: Relationship to Patient/Plan Member: Print Name of Patient/Plan Member's Representative: inda Caldwell

| UNITED STATES |
|----------------|
| |
| POSTAL SERVICE |

Certificate Of Mailin

This Certificate of Mailing provides avidence that mail has been presented to USPS® for mailing this form may be used for domestic and international mail

From:

Trammell Piazza Law Firm, PLLC

418 North State Line Ave.

Texarkana, AR 71854

- SavaSeniorCare Consulting, LLC
- c/o The Corporation Company
328 Alexander Street, Suite 10
Marietta, GA, 30060

J.S. POSTAGE
J.S. POSTAGE
EXARKANA, AR
71854
J.G. 18 15
AMOUNT
R2305E125034-07

PS Form **3817**, April 2007 PSN 7530-02-000-9065

| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
|---|--|
| Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 1. Article Addressed to: SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 | A. Signature X |
| Marietta, GA, 30060 | ☐ Registered ☐ Insured Mail ☐ Priority Mail Express™ ☐ Receipt for Merchandise ☐ Collect on Delivery |
| 8 | 4. Restricted Delivery? (Extra Fee) ☐ Yes |
| 2. Article Number (Transfer from service label) 7011 350 | 1105 7817 2011 |
| PS Form 3811, July 2013 Domestic | Return Receipt |

| 2011 | U.S. Postal S CERTIFIEL (Domestic Mail O |) M | AIL::: RE | CEIPT Coverage Provided) |
|------------------|---|--------------|---|--------------------------------|
| | For delivery informa | 1 1 | isit our website | at www.usps.com |
| 1 3500 0002 7817 | Postage Certified Fee Return Receipt Fee (Endorsement Required) Restricted Delivery Fee (Endorsement Required) **O Total Pc SavaSe C/o The | 71 nior(| \$3.45 \$2.80 \$0.00 \$0.00 \$0.00 Care Consideration Co | 0504 07 Postmark Here |
| 7011 | or PO Bos Marietta PS Form 3800. August 2 | cand , GA | er Street, S | |

AFFIDAVIT OF PERSON MAILING NOTICE

| STATE OF ARKANSAS |) |
|-------------------|---|
| |) |
| COUNTY OF MILLER |) |

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

- 1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.
- 2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346, as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letter.

Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

Exhibit 3, which is a HIPAA compliant medical authorization permitting SavaSeniorCare Consulting, LLC to obtain complete medical records from each other provider being sent a notice.

Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell

Trammell Piazza Law Firm, PLLC

TN BPR No. 21146

418 N. State Line Avenue Texarkana, AR 71854

Subscribed and sworn to before me this Att day of November 2015.

My commission expires: 3-26-2

KELLEY VASQUEZ MY COMMISSION # 12386943



418 N. State Line Ave. Texarkana, AR 71854 ph 870.779.1860 fx 870.779.1861 tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell chad@trammellpiazza.com

Melody H. Piazza Virginia C. Trammell

Of Counsel Brian G. Brooks Eric T. Bishop Kimberly Norris Deborah Riordan

SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta. GA 30346

RE:

Sarah Katherine Rodgers

Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

August 18, 2015

- (A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.
- B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.
- (C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.
- (D) A list of the name and address of all providers being sent this notice is attached to this notice.
- (E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv Enclosure

Provider List

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System Suite 2021 800 S Gay Street Knoxville, TN 37929

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346 SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

| Section A: This section must | be completed for | all Aut | horizations | | | | |
|---|---|--|---|--|---------------------|--|------------------|
| Patient/Plan Member Name: | | Birth Date: | | | Social Security No. | (optional): | |
| 7 1 1 2 1 1 | | | 2/ | 1 | 415-30-9 | 090 | |
| Sarah Kather | The God | jers | 5-15 | -06 | | (13 - 30) | 070 |
| Provider's/Health Plun's Name | e: | | Recipient's Name: | avaSeniorCa | are (| Consulting, LLC | |
| Provider's/Health Plan's Addre | OSS: | | Address 1: | | | | |
| | | | Address 2: | | | | |
| | | | City: | | | State: | Zip: |
| This authorization will expire r | | (Fill in t Event: | he Date or the Event | but not both.) | | | |
| Purpose of disclosure: CC | OMPLIANCE W | ATH T. | C.A. § 29-26-121 | | | | |
| | Des | eription | of information to be | used or disclosed | i | | 7 |
| is this request for psychotherap another authorization for other | y notes? Yes, items below. | then thi | s is the only item you you may check as m | i may request on any items below | this at as you | uthorization. You nu need. | st submit |
| Description: | Date(s): | Descri | | Date(s) | | cription; | Date(s) |
| MAII PHI in medical record Admission form Dictation reports Physician orders Intake/outtake Clinical Test Medication Sheets | All Dates Of Service | Coperative Information Cath lab Special test/therapy Rhythm Strips Nursing Information Transfer forms ER Information | | All Dates Of Service | P OI | abor/delivery sum. B nursing assess ostpartum flow sheet emized bill: B-92: ther: diagnostic films ther: | and studies |
| I acknowledge, and hereby consecution or AIDS information. | sent to such, that | the relea | | contain alcohol, ere, ti | drug : | abuse, psychiatric, HI | v testing, HIV |
| I understand that: 1. I may refuse to sign this aut 2. My treatment, payment, env 3. I may revoke this authorizat revocation. Further details 4. If the requester or receiver i privacy regulations and may 5. I understand that I may see a 6. I get a copy of this form after | horization and the collment or eligibition at any time is may be found in a not a health plus be redisclosed, and obtain a copy | at it is si ility for in writing the Not an or hea | rictly voluntary. benefits may not be c but if I do, it will n ice of Privacy Practic alth care provider, the | onditioned on signot have any effecters. ereleased inform | ation a | may no longer he pro | lected by federa |
| Section B: (s the request of PH f yes, the health plan or health of | I for the purpose care provider mu | of mark st compl | eting? ete Section B, otherw | vise skip to Section | on C. | | |
| Will the recipient receive financ | | | | | | nformation? 🗆 Yes | □ No |
| If yes, describe: | | • | | | | | |
| ection C: Signatures | | - | | | | PAL WASHINGTON TO THE WASHINGTON | |
| CONTRACTOR STREET | | | | | | | |

Revised 3/2003



Date:

Relationship to Patient/Plan Member:

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Present/flan Member/Gugrdjan/Patient/Plan Member Representative:

Print Name of Patient/Plan Member's Representative:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: Sarah Katherine Rodgers 5-15-26 415-30-9090 Recipient's Name: Provider's/Health Plun's Name: SavaSeniorCare Consulting, LLC Address 1: Provider's/Health Plan's Address: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: Date: 7/11/6 Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121 Description of information to be used or disclosed Is this request for psychotherapy notes? 🗆 Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. WNo, then you may check as many items below as you need. Date(s) Date(s) Description: Description: Date(s): Description: Labor/delivery sum. Operative Information ra All PHI in medical record OB nursing assess □ Cath lab ri Admission form □ Postpartum flow sheet. 11 Special test/therapy L. Dictation reports n Itamized bill; a Rhythm Strips u Physician orders u Nursing Information □ UB-92: ii Intake/outtake Other: diagnostic films and studies Clinical Test □ Transfer forms □ ER Information D Other: ☐ Medication Sheets I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _______(Initial) If not applicable, check here, u I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it, 6. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🗆 Yes 🗆 No If yes, describe: Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardin/Patient/Plan Member Representative:

Date:

7-31-15

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Daughter

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: 5-15-26 415-30-9090 Sarah Katherine Kodgers SavaSeniorCare Consulting, LLC Address 1: Provider's/Health Plan's Address: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. In No, then you may check as many items below as you need. Description: Date(s) Date(s) Description: Date(s): Description: Labor/delivery sum. □ Operative Information ci All PHI in medical record OB nursing assess □ Cath lab a Admission form ti Special test/therapy □ Postpartum flow sheet Dictation reports D Itamized bill: u Rhytlun Strips in Physician orders ⊔ UB-92: Nursing Information ntake/outtake □ Other: diagnostic films | and studies □ Transfer forms Clinical Test □ ER Information Other: ப Medication Sheets I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, D I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🗆 Yes 🗆 No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Powent/Flan Member/Guardizh/Patient/Plan Member Representative: Relationship to Patient/Plan Member:

Revised 3/2003

Print Name of Patient/Plan Member's Representative:

| POSTAL SERVICE • | Certificate Of Mailing | |
|--|------------------------|---|
| This Certificate of Mailing provides evidence that qual This form and the International Providence that qual Trammell Plazza List 418 North State List Texarkana, AR 718 | ie Ave. | AGE VA, AR T5 S1 S1 S0 S1 S1 S50 S4-07 |
| SavaSeniorCare Co One Ravinia Drive, —Atlanta, GA 30346 | • | U.S. POST PAID TEXARKAN 71854 AUG 18 1 |
| PS Form 3817 , April 2007 PSN 7530- | 02-000-9065 | OSTITUTES STATINGES 0000 |

| SENDER: COMPLETE THIS | SECTION | COMPLETE THIS SECTION ON | DELIVERY |
|--|--|--|---|
| Complete items 1, 2, and 3. item 4 if Restricted Delivery Print your name and address so that we can return the call Attach this card to the back or on the front if space perm | is desired. s on the reverse and to you. of the mailpiece, | A. Signature X B. Received by (Printed Name) | ☐ Agent ☐ Addressee C. Date of Delivery |
| Article Addressed to: SavaSeniorCare Cons One Ravinia Drive, Su | | Is delivery address different fro if YES, enter delivery address | |
| Atlanta, GA 30346 | iile 1500 | | Receipt for Merchandise t on Delivery |
| Article Number (Transfer from service label) | 7011 3500 | 0002 7817 2004 | *************************************** |
| PS Form 3811, July 2013 | Domestic Ret | ım Receipt | |

U.S. Postal Service CERTIFIED MAIL RECEIPT 4002 7817 ATLANTA- GA 30346 Postage 0504 Certified Fee 07 000 \$2.80 \$0.00 \$0.00 Return Receipt Fee (Endorsement Required) Postmark Here Restricted Delivery Fee (Endorsement Required) \$0.00 3500 \$0.00 Total Postage & Fees \$ SavaSeniorCare Consulting, 225C One Ravinia Drive, Suite 1500 city, State, Atlanta, GA 30346

AFFIDAVIT OF PERSON MAILING NOTICE

| STATE OF ARKANSAS |) |
|-------------------|---|
| COUNTY OF MILLER |) |

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

- 1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.
- 2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346, as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letter.

Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

Exhibit 3, which is a HIPAA compliant medical authorization permitting SavaSeniorCare Administrative Services, LLC to obtain complete medical records from each other provider being sent a notice.

Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell

Trammell Piazza Law Firm, PLLC

TN BPR No. 21146

418 N. State Line Avenue Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

My commission expires: 3-28-2





418 N. State Line Ave. Texarkana, AR 71854 ph 870.779.1860 fx 870.779.1861 tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell chad@trammellpiazza.com

Melody H. Piazza Virginia C. Trammell

Of Counsel Brian G. Brooks Eric T. Bishop Kimberly Norris Deborah Riordan

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

RE:

Sarah Katherine Rodgers

Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

August 18, 2015

- (A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.
- B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.
- (C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.
- (D) A list of the name and address of all providers being sent this notice is attached to this notice.
- (E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv Enclosure

Provider List

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System
Suite 2021
800 S Gay Street
Knoxville, TN 37929

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346



SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

| AUTHORIZATI | ON FOR RE | LEAS. | E OF PROTECT | TED HEALT | H INFORMATIO | N (T | 'HI') | |
|---|--|---|--|-----------------------------------|--|--------|------------------|--|
| Section A: This section must l | Control of the Control | | | | | | | |
| Patient/Plan Member Name: | | | Birth Date: | | Social Security No. (optional): | | | |
| Sarah Katherine Rodgers | | 5-15 | 5-15-26 415-30-9090 | | | | | |
| Provider's/Health Plan's Name | 27 | | Recipient's Name: SavaSenio | orCare Adm | inistrative Servic | es, | LLC | |
| Provider's/Health Plan's Addre | ess: | | Address 1: | | | | | |
| | | | Address 2: | | | | 4 | |
| | | | City: | | State: | 2 | Vip: | |
| This authorization will expire on Date: 7/1/6 | n the following: | (Fill in t Event: | the Date or the Event | but not both.) | | | | |
| 11010 | IMPLIANCE W | TH T. | C.A. § 29-26-121 | | | -0, | | |
| | Des | cription | of information to be | used or disclosed | I | | | |
| is this request for psychotherap another authorization for other | y notes? Yes, items below. | then thi | is is the only item you I you may check as m | may request on any items below | this authorization. You as you need. | e ntus | t submit | |
| Description: | Date(s): | Descri | | Date(s) | Description: | | Date(s) | |
| MAII PHI in medical record Admission form Dictation reports Physician orders Intake/outtake Clinical Test Medication Sheets | All Dates Of Service | Operative Information Cath lab Special test/therapy Rhythm Strips Nursing Information Transfer forms ER Information | | All Dates Of Service | Deliabor/delivery sum. | | and studies | |
| I acknowledge, and hereby consecutive or AIDS information. | sent to such, that | the relea | 17 Telephone (1971) 17 Tel | contain alcohol, ere. 🗆 | drug abuse, psychiatric, | , HIV | testing, HIV | |
| 1 understand that: 1. I may refuse to sign this aut 2. My treatment, payment, one 3. I may revoke this authorizat revocation. Further details 4. If the requester or receiver i privacy regulations and may 5. I understand that I may see a 6. I get a copy of this form after | ollment or eligibition at any time in may be found in a nealth plate be redisclosed, and obtain a copy | lity for writing the Not in or he | benefits may not or c g, but if I do, it will n ice of Privacy Practic alth care provider, the | es. e released inform | nation may no longer be | prote | ected by federal | |
| Section B: Is the request of PH If yes, the health plan or health of | If for the purpose care provider mus | of mark | ceting? lete Section B, otherv | vise skip to Section | on C. | | | |
| Will the recipient receive financ | | | | | | es c | 1 No | |
| If yes, describe: | w | | Maria de la compansión de | | PERSONAL PROPERTY OF THE PARTY | | | |
| Section C: Signatures I have read the above and author | l the disalegans | of the | protected bealth infor | mation as stated. | | | | |
| Signature of Parenty lan Membe | er/Guardizh/Patic | 1.18 | | | Date: 7-31-1. | 5 | | |
| rint Name of Patient/Plan Member's Representative: Relationship to Patient/Plan Member: Laughter | | | | | | | | |



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Birth Date: Patient/Plan Member Name: 415-30-9090 5-15-26 Recipient's Name: Provider's/Health Plan's Name SavaSeniorCare Administrative Services, LLC Provider's/Health Plan's Address: Address 1: Address 2: State: Zin: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? - Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need. Date(s) Description: Date(s) Description: Description: Date(s): o Labor/delivery sum. Operative Information o All PHI in medical record □ OB nursing assess □ Cath lab n Admission form n Postpartum flow sheet II Special test/therapy ra Dictation reports n Itemized bill: n Rhytlun Strips ci Physician orders □ Nursing Information ப UB-92: iii Intake/outtake Other: diagnostic films and studies □ Transfer forms Clinical Test □ ER Information □ Other: u Medication Sheets I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV (Initial) If not applicable, check here, or results or AIDS information. I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🗆 Yes 🗅 No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Date: Signature of Powent/Plan Member/Guardizh/Patient/Plan Member Representative: Lalderell Relationship to Patient/Plan Member: Print Name of Patient/Plan Member's Representative: Coldwel inda

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Birth Date: Patient/Plan Member Name: 415-30-9090 5-15-26 Recipient's Name: Provider's/Health Plan's Name: SavaSeniorCare Administrative Services, LLC Address 1: Provider's/Health Plan's Address: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? XYes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

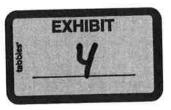
No, then you may check as many items below as you need. Date(s) Description: Date(s) Date(s): Description: Description: a Operative Information o Labor/delivery sum. O All PHI in medical record OB nursing assess Cath lab rt Admission form D Postpartum flow sheet. 11 Special test/therapy Dictation reports □ Itamized bill: tı Rhytlun Strips m Physician orders ⊔ UB-92: a Nursing Information Intake/outtake Other: diagnostic films and studies ☐ Transfer forms Clinical Test Other: □ ER Information ☐ Medication Sheets l acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. l understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? Tyes DNo If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Parent/Han Member/Guardizh/Patient/Plan Member Representative: Date: Print Name of Patient/Plan Member's Representative:

| UNITED STATES | |
|------------------|--|
| POSTAL SERVICE • | |

Certificate Of Mailing

| From: | orthcate of Mailing provides evidence that mail has been prosented to USFSE for inading informational mail. Traininell Plazza Law Firm, PLLC 418 North State Line Ave. Texarkana, AR 71854 |
|----------|---|
| - To: | SavaSeniorCare Administrative Services, One Ravinia Drive, Suite 1500 Atlanta, GA 30346 |
| PS F | form 3817 , April 2007 PSN 7530-02-000-9065 |





| SENDER: COMPLETE THIS S. | ECTION | COMPLETE THIS SECTION ON DE | LIVERY |
|--|---|--|-----------------------|
| Complete items 1, 2, and 3. A item 4 if Restricted Delivery is Print your name and address so that we can return the card Attach this card to the back or on the front if space permit 1. Article Addressed to: SavaSeniorCare Admir One Ravinia Drive, Sui Atlanta, GA 30346 | desired. on the reverse d to you. of the mailpiece, ts. nistrative Servi | B. Received by Printed Name) D. Is delivery address different from its If YES, enter delivery address beloces, LLC | |
| Attained, Circoso is | | 3. Service Type Certified Mail® Priority Ma Registered Return Re Insured Mail Collect on 4. Restricted Delivery? (Extra Fee) | ceipt for Merchandise |
| Article Number (Transfer from service label) | 7011 35 | 00 0002 7817 2035 | |
| PS Form 3811 July 2013 | Domestic I | Domestic Return Receipt | |

U.S. Postal Service 110 CERTIFIED MAIL RECEIPT 2035 (Domestic Mail Only; No Insurance Coverage Provided) \$2.80 we Services. 0. \$0.80 we Services. 0. \$0.80 500 7817 0504 07 Postage Certified Fee 7011, 3500 0002 Postmark Return Receipt Fee (Endorsement Required) Here Restricted Delivery Fee (Endorsement Required) Sava Senunda Drive,
One Ravina Orive,
Atlanta, GA 30346 City, S.

AFFIDAVIT OF PERSON MAILING NOTICE

| STATE OF ARKANSAS |) |
|-------------------|---|
| COUNTY OF MILLER |) |

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

- 1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.
- 2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA 30060, as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letter.

Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

Exhibit 3, which is a HIPAA compliant medical authorization permitting SavaSeniorCare Administrative Services, LLC c/o The Corporation Company to obtain complete medical records from each other provider being sent a notice.

Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammell

Trammell Piazza Law Firm, PLLC

TN BPR No. 21146

418 N. State Line Avenue Texarkana, AR 71854

Subscribed and sworn to before me this at day of November, 2015.

My commission expires: 3 - 36 - 32

KELLEY VASQUEZ MY COMMISSION # 12386943 EXPIRES: March 28, 2022 Miller County



418 N. State Line Ave. Texarkana, AR 71854 ph 870.779.1860 fx 870.779.1861 tf 888.989.1860

TrammellPiazza.com

M. Chad Trammell chad@trammellpiazza.com

Melody H. Piazza Virginia C. Trammell

Of Counsel Brian G. Brooks Eric T. Bishop Kimberly Norris Deborah Riordan

August 18, 2015

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

RE:

Sarah Katherine Rodgers

Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

- (A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.
- B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.
- (C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.
- (D) A list of the name and address of all providers being sent this notice is attached to this notice.
- (E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv Enclosure

Provider List

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System Suite 2021 800 S Gay Street Knoxville, TN 37929

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346 SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Birth Date: Patient/Plan Member Name: 415-30-9090 5-15-26 Provider's/Health Plan's Name SavaSeniorCare Administrative Services, LLC Address 1: Provider's/Health Plan's Address: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed is this request for psychotherapy notes? 🗆 Yes, then this is the only item you may request on this authorization. You must submit another authorization for other iterus below. No, then you may check as many items below as you need. Date(s) Date(s) Description: Description: Date(s): Description: Operative Information Labor/delivery sum. All PHI in medical record OB nursing assess Cath lab All Dates Admission form All Dates Postpartum flow sheet. Special test/therapy Dictation reports Of Service Of Service M Rhytlum Strips Mursing Information o Physician orders 16 UB-92: fintake/outtake M Transfer forms Other: diagnostic films and studies Clinical Test a Other: Medication Sheets ER Information I acknowledge, and hereby consenute such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, D I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. [get a copy of this form after I sign it.

| Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to | Section C. |
|--|--------------------------------------|
| Will the recipient receive financial or in-kind compensation in exchange for using or dis | closing this information? □ Yes □ No |
| If yes, describe: | |
| Section C: Signatures | |
| I have read the above and authorize the disclosure of the protected health information as | stated. |
| Signature of Parenty lan Member/Guardien/Patient/Plan Member Representative: | Date: 7-31-15 |
| Print Name of Pagent/Plan Member's Representative: | Relationship to Patient/Plan Member: |

Revised 3/2003

inola

Daughter

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: 415-30-9090 Sarah Katherine Rodgers 5-15-26 Recipient's Name: Provider's/Health Plan's Name: SavaSeniorCare Administrative Services, LLC Address I: Provider's/Health Plan's Address: Address 2: Zip: State: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes?

Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. X No, then you may check as many items below as you need. Date(s) Date(s) Description: Description: Date(s): Description: Labor/delivery sum. Operative Information ci All PHI in medical record OB nursing assess □ Cath lab n Admission form D Postpartum flow sheet. 11 Special test/therapy LI Dictation reports □ Itemized bill: u Rhytlun Strips Physician orders ⊔ UB-92: u Nursing Information in Intake/outtake Other: diagnostic films and studies Transfer forms Clinical Test Other: □ ER Information □ Medication Sheets I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ______ (Initial) If not applicable, check here. □ I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🗆 Yes 🗆 No If yes, describe: Section C: Signatures have read the above and authorize the disclosure of the protected health information as stated. Signature of Purent Plan Member/Guardizh/Patient/Plan Member Representative: Date: Relationship to Patient/Plan Member: Print Name of Patient/Plan Member's Representative: -inola Coldwel

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: Katherine Kodgers 415-30-9090 5-15-26 Provider's/Health Plan's Name: SavaSeniorCare Administrative Services, LLC Address I: Provider's/Health Plan's Address: Address 2: Zin: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? XYes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

No, then you may check as many items below as you need. Date(s) Description: Date(s) Date(s): Description: Description: □ Operative Information Labor/delivery sum. n All PHI in medical record OB nursing assess cath lab ra Admission form n Postpartum flow sheet in Special test/therapy ra Dictation reports Itemized bill: n Rhythm Strips n Physician orders ы UB-92: LI Nursing Information u Intake/outtake Other: diagnostic films and studies □ Transfer forms Clinical Test □ ER Information Other: m Medication Sheets I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? \Box Yes \Box No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Papent/Plan Member/Guardizh/Patient/Plan Member Representative: Date: alderely Relationship to Patient/Plan Member: Print Name of Patient/Plan Member's Representative: Linda Coldwell

| UNITED STATES POSTAL SERVICE | Certificate Of Mailing |
|------------------------------|---|
| Trammell 418 North | Piazza Law Firm, PLLC State Line Ave. a, AR 71854 |
| | Care Administrative Service poration Company ler Street, Suite 10 A, 30060 |

PS Form **3817**, April 2007 PSN 7530-02-000-9065







AFFIDAVIT OF PERSON MAILING NOTICE

| STATE OF ARKANSAS |) |
|-------------------|---|
| COUNTY OF MILLER |) |

Comes now the Affiant, M. Chad Trammell, who, having first been duly sworn, makes oath that the following statements are true:

- 1. My name is M. Chad Trammell. I am an adult citizen, over the age of eighteen (18) years, and am competent to make the statements contained in this Affidavit.
- 2. On August 18, 2015, I mailed by certified mail, with return receipt requested, after obtaining a Certificate of Mailing from the U.S. Postal Service, stamped with the date of August 18, 2015, the below notice and all enclosures to SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346, as required by T.C.A. § 29-26-121(a):

Exhibit 1, which is the notice letter.

Exhibit 2, which is the list of the name and address of all providers who were being sent notice pursuant to T.C.A. § 29-26-121(a).

Exhibit 3, which is a HIPAA compliant medical authorization permitting SavaSeniorCare, LLC to obtain complete medical records from each other provider being sent a notice.

Exhibit 4, which is a copy of the Certificate of Mailing from the U.S. Postal Service, stamped with the date of mailing.

Exhibit 5, which is a copy of the return receipt card that accompanied the notice letter sent by certified mail.

M. Chad Trammelf

Trammell Piazza Law Firm, PLLC

TN BPR No. 21146

418 N. State Line Avenue Texarkana, AR 71854

Subscribed and sworn to before me this 24th day of November, 2015.

NOTARY PUBLIC

My commission expires: 3-28-22

KELLEY VASQUEZ
MY COMMISSION # 12386943
EXPIRES: March 26, 2022
Miller County



418 N. State Line Ave. Texarkana, AR 71854 ph 870.779.1860 fx 870.779.1861 tf 888.989.1860

Melody H. Piazza

M. Chad Trammell

Virginia C. Trammell

chad@trammellpiazza.com

Of Counsel Brian G. Brooks Eric T. Bishop

Kimberly Norris

Deborah Riordan

TrammellPiazza.com

August 18, 2015

SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

RE:

Sarah Katherine Rodgers

Notice required by T.C.A. § 29-26-121(a)

Dear Sir/Madam:

The purpose of this letter is to comply with the terms of TCA s 29-26-121(a) and inform you of a potential claim of health care liability asserted against you. In compliance with the statute, you are informed of the following:

- (A) The full name and date of birth of the patient whose treatment is at issue is Sarah Katherine Rodgers, date of birth, 05/15/1926.
- B) The name and address of the claimant authorizing the notice is Linda Rodgers, Personal Representative, 6523 Moonshell Ct., Orlando, FL 32819.
- (C) The name and address of the attorney sending the notice is M. Chad Trammell, 418 N. State Line Avenue, Texarkana, Arkansas 71854.
- (D) A list of the name and address of all providers being sent this notice is attached to this notice.
- (E) A HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice is attached to this notice.

While a resident at Lebanon Health and Rehabilitation Center, Sarah Katherine Rodgers suffered malnutrition, a large and deep pressure ulcer, urinary tract infections, which ultimately led to her death on November 6, 2014.

Kindest regards,

M. Chad Trammell

MCT/kv Enclosure

Provider List

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 731 Castle Heights Court Lebanon, TN 37087

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center 1 Ravinia Drive Suite 1500 Atlanta, GA 30346

SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center c/o C T Corporation System Suite 2021 800 S Gay Street Knoxville, TN 37929

SMV Lebanon, LLC 45 Broadway, Suite 520 New York, NY 10006

SMV Lebanon, LLC c/o VCORP Services, LLC 15439 Old Hickory Blvd Nashville, TN 37211

SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Administrative Services, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SavaSeniorCare Administrative Services, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

SavaSeniorCare Consulting, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346 SavaSeniorCare Consulting, LLC c/o The Corporation Company 328 Alexander Street, Suite 10 Marietta, GA, 30060

Tennessee HoldCo, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

SSC Submaster Holdings, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346

| AUTHORIZATI | ON FOR RE | LEAS | E OF PROTECT | red healt | HI | NFORMATION (| PHI) | |
|--|--|---|--|--|----------------------------|---|-------------------|--|
| Section A: This section must | | | | | | | | |
| Patient/Plan Member Name: | | | Birth Date: | | | Social Security No. | | |
| Sarah Kather | ine Rodg | ers | 5-15 | -26 | | 415-30-9 | 7090 | |
| II. | Provider's/Health Plun's Name: | | | SavaSe | enio | Care, LLC | | |
| Provider's/Health Plan's Address: | | Address 1: | | | | | | |
| | | | Address 2: | Address 2: | | | | |
| | | | City: | | | State: | Zip: | |
| This authorization will expire to Date: 7/1/6 | n the following: | (Fill in Event: | the Date or the Event | but not both.) | | 116 1 1 1 1 1 1 1 | | |
| | IMPLIANCE W | ITH T | C.A. § 29-26-121 | | | | | |
| | Des | cription | of information to be | used or disclosed | ı | | | |
| is this request for psychotherap another authorization for other | y notes? - Yes, items below. | then the | is is the only item you n you may check as m | may request on any items below | this a as yo | uthorization. You m u need. | ust submit | |
| Description: | Date(s): | | iption: | Date(s) | | cription: | Date(s) | |
| All PHI in medical record Admission form Dictation reports Physician orders Intake/outtake Clinical Test Medication Sheets | All Dates Of Service | M Cati M Spec M Rhy M Nur M Frau | rative Information I lab It la | All Dates Of Service | N PO N It N U N U | abor/delivery sum. B nursing assess ostpartum flow sheet emized bill: B-92: ther: diagnostic film ther: | s and studies | |
| I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HI results or AIDS information. (Initial) If not applicable, check here. u | | | | | | V testing, HIV | | |
| I understand that: I. I may refuse to sign this aut My treatment, payment, one That revocation. Further details fithe requester or receiver is privacy regulations and may Lunderstand that I may see to get a copy of this form after | horization and the ollment or eligibition at any time is may be found in is not a health place be redisplosed, and obtain a copy | nt it is s lity for writing the Not n or he | iricily voluntary. benefils may not be c g, but if I do, it will n ice of Privacy Practic alth care provider, the | onditioned on sig ot have any effects. e released inform | ation | may no longer he pro | ntected by federa | |
| Section B: Is the request of PH If yes, the health plan or health | I for the numose | of mark | reting? lete Section B, otherw | rise skip to Section | on C. | , , , , , , , , , , , , , , , , , , , | | |
| | | | | | | information? D'Yes | □ No | |
| Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No If yes, describe: | | | | | | | | |
| Section C: Signatures | | | | | | | | |
| have read the above and author | ize the disclosure | of the | protected health infor | mation as stated. | | 1,700 | | |
| | ignature of Parent Plan Member/Guardian/Patient/Plan Member Representative: Oate: 7-31-15 | | | | | | | |
| Print Name of Pagent/Plan Mem | ber's Representat well | ive: | | | Relat | ionship to Patient/Pla Daughter | | |

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: 415-30-9090 Sarah Katherine Rodgers 5-15-26 Recipient's Name: SavaSeniorCare, LLC Address I: Provider's/Health Plan's Address: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes?

Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. KNo, then you may check as many items below as you need. Description: Date(s) Date(s) Description: Date(s): Description: a Labor/delivery sum. □ Operative Information a All PHI in medical record □ OB nursing assess □ Cath lab n Admission form □ Postpartum flow sheet. ii Special test/therapy ti Dictation reports o Itemized bill: a Rhytium Strips n Physician orders ப் Nursing Information □ UB-92: u Intake/outtake Other: diagnostic films and studies □ Transfer forms Clinical Test o Other: ER Information ☐ Medication Sheets I acknowledge, and hereby consenue such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _______(Initial) If not applicable, check here. □ I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed, I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? TYes TNo If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Purent/Plan Member/Guardizh/Patient/Plan Member Representative: Relationship to Patient/Plan Member: Print Name of Patient/Plan Member's Representative: inda Caldwell

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) Section A: This section must be completed for all Authorizations Social Security No. (optional): Patient/Plan Member Name: 5-15-26 415-30-9090 Katherine Rodgers SavaSeniorCare, LLC Recipient's Name: Provider's/Health Plan's Address: Address 1: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? XYes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. DNo, then you may check as many items below as you need. Date(s) Description: Date(s) Description: Date(s): Description: Labor/delivery sum. □ Operative Information ri All PHI in medical record OB nursing assess Cath lab ra Admission form □ Postpartum flow sheet. 11 Special test/therapy Dictation reports n Itemized bill: n Rhythm Strips rı Physician orders □ UB-92: D Nursing Information u Intake/outtake Other: diagnostic films and studies ☐ Transfer forms Clinical Test Other: □ ER Information u Medication Sheets I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here, to I understand that: I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer he protected by federal privacy regulations and may be redisclosed. 5. Lunderstand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. Section B: Is the request of PHI for the purpose of marketing? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? 🗆 Yes 🗆 No If yes, describe: Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Parenty lan Member/Guardizh/Patient/Plan Member Representative: Date: Print Name of Patient/Plan Member's Representative:

Revised 3/2003

-inda Caldwell

| This Co This for | Certificate thicate of Making provides evidence that must have been presented to use may be presented for domestic and incornational mail. I rammell Plazza Law Firm | ISPS® for mail: |
|---------------------|---|-----------------|
| From: | Trammell Piazza Law Firm | n PII |
| _ | 418 North State Line Ave | |
| - | Texarkana, AR 71854 | |
| Fo: — | SavaSeniorCare, LLC One Ravinia Drive, Suite 1500 Atlanta, GA 30346 | |
| | | 1000 |

U.S. POSTAGE
TEXARKANA, AR
71854
AUG 18 15
AMOUNT
R2305E125034-07

| COMPLETE THIS SECTION ON DELIVERY | | |
|---|--|--|
| A. Signature X | | |
| D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No | | |
| 3. Service Type Certified Mail® ☐ Priority Mail Express™ ☐ Registered ☐ Priority Mail Express™ ☐ Registered ☐ Collect on Delivery 4. Restricted Delivery? (Extra Fee) ☐ Yes | | |
| U 0002 7817 2028 | | |
| | | |

| 2028 | U.S. Postal Service TO CERTIFIED MAIL TO RECEIPT (Domestic Mail Only; No Insurance Coverage Provided) For delivery information visit our website at www.usps.com OF ATLANTA: GA 30346 | | | | |
|---------------|---|--|---------|--|--|
| 500 0002 7817 | Postage \$ Certified Fee Return Receipt Fee (Endorsement Required) Restricted Delivery Fee | \$3.45 0504 07 \$2.80 Postmark \$0.00 \$0.00 \$0.00 | | | |
| 7011 3 | Sent To Sava Senior C | Sare, LLC 08/18/2015 Drive, Suite 1500 30346 | ictions | | |

EXHIBIT

"B"

IN THE CIRCUIT COURT OF TENNESSEE FOR THE FIFTEENTH JUDICIAL DISTRICT AT LEBANON, WILSON COUNTY

| Linda Caldwell, as Next of Kin of Sarah Katherine | | | | |
|---|----------|-------------|--|--|
| Rodgers, Deceased, and on behalf of the wrongful death beneficiaries of Sarah Katherine Rodgers | | Plaintiff, | | |
| $\mathbf{V}_{\mathbf{c}_{\mathbf{c}_{\mathbf{c}_{\mathbf{c}_{\mathbf{c}}}}}}$ | Cause No | = | | |
| SSC Lebanon Operating Company, LLC d/b/a Lebanon Health and Rehabilitation Center; SMV Lebanon, LLC; Sava SeniorCare, LLC; Sava SeniorCare Administrative Services, LLC; Sava SeniorCare Consulting, LLC; Tennessee Hold LLC; SSC Submaster Holdings, LLC | łCo, | Defendants. | | |

CERTIFICATE OF GOOD FAITH

Medical malpractice case

PLAINTIFF'S FORM

- A. In accordance with T.C.A. § 29-26-122, I hereby state the following: (Check item 1 or 2 below and sign your name beneath the item you have checked, verifying the information you have checked. Failure to check item 1 or 2 and/or not signing item 1 or 2 will make this case subject to dismissal with prejudice.)
- 1. The Plaintiff or Plaintiff's counsel has consulted with one (1) or more experts who have provided a signed written statement confirming that upon information and belief they:
 - (A) Are competent under § 29-26-115 to express opinion(s) in the case; and
 - (B) Believe, based on the information available from the medical records concerning the care and treatment of Jeanette Glasgow, deceased, for the incident(s) at issue, that there is a good faith basis to maintain the action consistent with the requirements of § 29-26-115.

Total Manual Constitution of District of the second of Signature

Signature of Plaintiff if not represented, or Signature of Plaintiff's Counsel

Or

- The Plaintiff or Plaintiff's counsel has consulted with one (1) or more experts who have provided a signed written statement confirming that upon information and belief they:
 - (A) Are competent under § 29-26-115 to express opinion(s) in the case; and
 - Believe, based on the information available from the medical (B) records reviewed concerning the care and treatment of the Plaintiff for the incident(s) at issue, and as appropriate, information from the Plaintiff or others with knowledge of the incident(s) at issue, that there are facts material to the resolution of the case that cannot be reasonably ascertained from the medical records or information reasonably available to the Plaintiff or Plaintiff's counsel; and that despite the absence of this information there is a good faith basis for maintaining the action as to each Defendant consistent with the requirements of § 29-26-115. Refusal of the Defendant to release the medical records in a timely fashion, or where it is impossible for the Plaintiff to obtain the medical records shall waive the requirement that the expert review the medical records prior to expert certification.

Signature of Plaintiff if not represented, or Signature of Plaintiff's Counsel

B. You MUST complete the information below and sign:

I have been found in violation of T.C.A. § 29-26-122 -0- prior times. (Insert number of prior violations by you.)

Signature of Person Executing this Document

Data